Nourish Wellness Family Medicine
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Updated Pediatric Medical History

PATIENTS NAME:_____ **SEX:**_____ **DATE OF BIRTH:**_____

YOUR RELATIONSHIP TO PATIENT: _____
REASON FOR VISIT:
What concerns is the patient seeing the provider for today? (Please list all concerns, how long, and how often).

_____

_____

_____

MEDICINES/VITAMINS: _____
ALLERGIES TO MEDICINES AND REACTION: _____

NUTRITION & FEEDING

Was your child breastfed? __No __Yes If so, how long? _____
Has your child had any unusual feeding/diet problems? __ No __Yes If yes, specify _____
_____
Milk intake now: Type: __Cow's milk (__ Nonfat __1% Fat __2% Fat __Whole milk)
__ Soy Milk __ Rice Milk Average Ounces Per Day (8 ounces=1 cup) _____

SLEEP

Hours per night: _____ Naps (number & length): _____

DEVELOPMENT

At what age did your child: Sit alone:_____ Walk alone: _____ Say words: _____

Toilet train (daytime):_____ Girls only: Age of first menstrual period: _____

DENTAL HISTORY

Has child been seen by dentist? __No __Yes If so, how often? _____ Date of last visit: _____

IMMUNIZATIONS/INFECTIOUS DISEASES: ***Please bring child's immunization records to appointment***

Has your child had: __ Chicken Pox __ Measles __Mumps __Rubella __Meningitis __ Tuberculo

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) __No __Yes
Do any household members smoke? __ No __ Yes
TV- hours per day: _____ Computer- hours per day: _____ Video games- hours per day: _____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.

_____
_____
_____

Hospitalizations/Operations/Broken bones (with dates): _____
_____
_____

FAMILY HISTORY: (Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart Disease	Thyroid Disease
Cancer	Stroke	Psychiatric Disorders
Kidney Disease	High Blood Pressure	Asthma/Hay Fever/Eczema
Diabetes	Seizures	Bleeding/Clotting Problems

SOCIAL HISTORY:

Are the child's parents: __ Married __ Separated __Divorced
Parents Occupation: Mother's: _____ Father's: _____
Child care situation: __ Parents __Other Please specify: _____
Concerns about your child: __ Alcohol use __ Tobacco __Sexual Activity __Aggressive Behavior
Is violence at home a concern: __ No __ Yes Are there guns in the home? __No __Yes
Does your child drink __ City water __Well water __Bottled water

SCHOOL HISTORY:

Did/does your child attend school or preschool? __ No __Yes
Current grade: _____ Name of School: _____
Any concerns about school performance? _____
Any concerns about relationship with: Teachers __No __ Yes
Students __No __ Yes
Sports/exercise: (Type/How often/How long): _____

REVIEW OF SYSTEMS: If child has more than one symptom on a line, circle the relevant one(s).

Constitutional/Endocrine
- __ Fevers/chills/excessive sweating
- __ Unexplained weight loss/gain

Eyes
- __ Squinting/Crossed eyed

Ears/Nose/Throat
- __ Hard of hearing
- __ Mouth breathing/snoring
- __ Bad Breath
- __ Frequent runny nose
- __ Problems with teeth/gums

Respiratory
- __ Cough/Wheeze

Gastrointestinal
- __ Nausea/vomiting/diarrhea
- __ Constipation
- __ Blood in bowel movement

Cardiovascular
- __Tires easily with exertion
- __Shortness of breath
- __Fainting

Neurological
- __Headaches
- __Weakness
- __Clumsiness

Muscular/Skeletal
- __Muscle/joint pain

Allergy
- __Hay Fever/itchy eyes

Skin
- __Rashes
- __ Unusual moles

Psychiatric/Emotional
- __ Speech Problems
- __ Anxiety/Stress
- __ Problems with sleep
- __ Depression
- __ Nail biting/thumb sucking
- __ Bad temper/Bedwetting

Blood/Lymph
- __ Unexplained lumps
- __ Easy bruising/bleeding

OTHER COMMENTS

Do you have any other comments for the doctor or nurse? Please share any additional information you feel would be helpful for your health care provider to best meet your child's needs.

_____
_____
_____
_____
_____

Parent/Guardian Signature_____ Date_____

Physician Reviewed _____ Date _____