Oskie Pediatrics

Medical History Form

Please print your child's name:_____
What primary concern do you wish me to address today?_____

_____

There are many questions below that I ask you to answer. They may help me better understand how to treat the concern that brought your child here today. They might also remind you of other issues you'd like addressed. Depending on their nature, some of these issues may be covered today and some others may require a separate office visit so I can give them the time and attention they deserve.

Please list any medicines your child is currently taking, including doses and times. Use the back of this page you need additional room.

_____
_____
_____

Please list any allergies or bad reactions your child has had to medications:

_____
_____

Does anyone in the household smoke, even if only outside the home? ____Y ____N

Does your child follow a special diet? **N Y** What? _____
Was your child born at term, prematurely or later than expected? _____
Was the delivery a C-Section or Vaginal delivery?_____
If the delivery was by C-Section, why was it needed?_____
Were there any conditions that caused your child to need a prolonged stay in the hospital after delivery? **N Y**
What? _____

Are childhood vaccinations up to date? **Y N** (please provide a copy of your child's immunization record)
Are there specific *children's health* problems that are common in your family or history of unexplained deaths at a young age? **Y N** list below

_____

Medical History/ Review of Symptoms: Please answer yes for any symptoms your child has experienced in the past year.

Please circle ***the specific item*** **for any yes answers**

Y N Illnesses or injury requiring an overnight hospital stay
Y N Seizures
Y N Eye disorders or impaired vision (except glasses)
Y N Ear disorders, frequent ear infections, loss of hearing
Y N Heart problems, murmur
Y N Muscular disease
Y N Lung disease, asthma, frequent night time cough
Y N Kidney disease, urinary incontinence or infections

Y N Liver disease
Y N Digestive problems, constipation or diarrhea, vomitting
Y N Blood sugar problems
Y N Learning difficulties, behavioral problems at home or school greater than most other children your child's age.
Y N Abnormalities in growth
Y N Sleep difficulties
Y N History of broken bones
Y N Chronic runny nose, cough, mouth breathing, snoring
Y N Other conditions not listed above (list below)

_____
_____
_____
_____
_____
_____

For Girls:
Y N Has your daughter started her menstrual cycle yet,
and at what age if she has started? _____

Has your child ever had any surgeries? N Y Please list below, include approximate date:

_____
_____

Review of symptoms that have troubled your child *over the past month*:

Please circle the Y or N for each question & Please circle ***the specific item*** **for any yes answers**

Y N Unexplained weight change, fevers, chills or night sweats
Y N Vision changes, eye pain, redness, irritation, Light bothering eyes, double vision, blurred vision
Y N Hearing loss, nasal congestion, snoring
Y N Chest pain, feeling unusual heartbeats, Fainting,
Y N Shortness of breath at rest or increasing with exercise, chronic cough
Y N Nausea, vomiting, diarrhea, changes in stool.
Y N Urinary urgency, increased frequency or pain. Frequent nighttime urination.
Y N Any muscular weakness or pain?
Y N Rashes or itching, non-healing sores, easy bruising or bleeding tendencies.
Y N Frequent headaches, loss of consciousness, numbness, weakness.
Y N Excessive thirst, feeling unusually hot, cold or tired?
Y N Lymph node swelling or pain
Y N Problems with depression or anxiety
Y N Problems with allergy?

Other conditions not listed above (describe below)

_____
_____
_____
_____
_____

Signed: _____ **Date:** _____
Relationship _____