# Piper Family Medicine, PC

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**Pediatric Medical History Form**

Today's Date: _____

Patient Name: _____ Date of Birth: _____

| **Personal Medical History (Include all conditions, even those controlled by medication)** | | | |
|---|---|---|---|
| | Yes | No | Comments |
| Diabetes | | | |
| High Blood Pressure | | | |
| Liver Problems | | | |
| Kidney Problems | | | |
| Heart Disease (Specify) | | | |
| Asthma | | | |
| ADD/ADHD | | | |
| Acid Reflux | | | |
| Chronic Ear/Throat Problems | | | |
| Other (Specify) | | | |

| **For Girls:** | | | |
|---|---|---|---|
| Has she started her period? | Yes | No | Age started: |

| **Vaccinations: (Provide copy of vaccinations received)** | | |
|---|---|---|
| Child has up to date vaccinations | Yes | No |

**Current Medications & Dosage:**

_____
_____
_____
_____
_____
_____

**Medication Allergies & Reactions:**

_____
_____
_____
_____
_____
_____

**Surgical/Procedural History & Dates:**

_____
_____
_____
_____
_____
_____

| **Personal Social History:** | | | |
|---|---|---|---|
| School: | | | Grade: |
| Activities: | | | |
| | | | |
| | | | |
| Behavioral Problems: | | | |
| | | | |
| | | | |
| Exercise | Yes | No | Hours per week: |
| Secondhand Smoke Exposure | Yes | No | |

**Family Medical History:** Please list any major ongoing medical problems (specifically high blood pressure, heart disease, stroke, diabetes, cancer and any other pertinent conditions), and if applicable, age at death and cause of death.

| **Mother/Mother's side of family:** | **Father/Father's side of family:** | **Siblings:** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| **Review of Systems:** | | | |
|---|---|---|---|
| Do you have problems with: | Yes | No | Please explain |
| Ears | | | |
| Eyes | | | |
| Nose | | | |
| Throat | | | |
| Head | | | |
| Neck | | | |
| Chest/Lungs | | | |
| Stomach | | | |
| Kidneys/Bladder | | | |
| Bowels | | | |
| Reproductive Organs | | | |
| Arms/Hands | | | |
| Legs/Feet | | | |
| Muscles/Joints | | | |
| Skin | | | |
| Back/Spine/Nerves | | | |
| Others | | | |
| **Main Objective of Today's Visit:** Of all your health questions and concerns, what would you most like to be addressed during today's visit? | | | |