

Past Medical History (page 1)



Pediatric Health Care Alliance, P.A.

Your Child's Medical Home™

Patient Name: _____ D.O.B.: _____

General Health

<input type="checkbox"/> Premature birth	<input type="checkbox"/> Congenital abnormalities (e.g. cleft palate, heart defect)
<input type="checkbox"/> Birth weight less than 5.5 lbs.	<input type="checkbox"/> Hospitalizations

Allergies

<input type="checkbox"/> None	<input type="checkbox"/> Food allergies (e.g. peanuts, eggs milk)
<input type="checkbox"/> Environmental allergies (e.g. pollen, dust)	<input type="checkbox"/> Medication allergies (e.g. antibiotics, aspirin)
<input type="checkbox"/> Other allergies (e.g. insect stings, latex)	<input type="checkbox"/>

ENT

<input type="checkbox"/> None	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Recurrent ear infections	<input type="checkbox"/> Tongue tied
<input type="checkbox"/> Enlarged tonsils	<input type="checkbox"/> Recurrent sinusitis
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Enlarged adenoids

Dermatology

<input type="checkbox"/> None	<input type="checkbox"/> Eczema
<input type="checkbox"/> Acne	<input type="checkbox"/> Psoriasis

Developmental

<input type="checkbox"/> None	<input type="checkbox"/> Developmental delay (e.g. speech, motor skills)
<input type="checkbox"/> Learning disabilities or difficulties	<input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD)
<input type="checkbox"/> Autism Spectrum Disorder (ASD)	<input type="checkbox"/> Speech Delay
<input type="checkbox"/> Language Delay	

Respiratory History

<input type="checkbox"/> None	<input type="checkbox"/> Asthma
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Inhaler or nebulizer

Cardiovascular History

<input type="checkbox"/> None	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Congenital heart disease	<input type="checkbox"/> High blood pressure (hypertension)
<input type="checkbox"/> Arrhythmias	<input type="checkbox"/> Syncope (fainting)

Past Medical History (page 2)

Patient Name: _____ D.O.B.: _____

Gastrointestinal History

<input type="checkbox"/> None	<input type="checkbox"/> Gastroesophageal reflux (GERD)
<input type="checkbox"/> Constipation	<input type="checkbox"/> Celiac disease
<input type="checkbox"/> Food intolerances or sensitivities	<input type="checkbox"/> Gallbladder disease
<input type="checkbox"/> Inflammatory bowel disease	<input type="checkbox"/> Hepatitis

Muskuloskeletal History

<input type="checkbox"/> None	<input type="checkbox"/> Fractures or broken bones
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Juvenile arthritis

Endocrine History

<input type="checkbox"/> None	<input type="checkbox"/> Diabetes type 1
<input type="checkbox"/> Diabetes type 2	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Growth hormone deficiencies	<input type="checkbox"/> Adrenal disorders
<input type="checkbox"/> Obesity	

Neurological History

<input type="checkbox"/> None	<input type="checkbox"/> Seizures (e.g. febrile or other)
<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines
<input type="checkbox"/> Head injury	<input type="checkbox"/> Concussion
<input type="checkbox"/> Fainting or loss of consciousness	<input type="checkbox"/> Tics or other movement disorders
<input type="checkbox"/> Sleep disorders (e.g. sleep apnea, insomnia)	

Other History

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Completed by (printed name): _____ Relationship to patient: _____

Signature: _____ Date: _____

Family History



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Does the patient's Mother , Father or sibling(s) have any of the following history.				
Skin	<input type="checkbox"/> Eczema	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Ichthyosis	
Eyes	<input type="checkbox"/> Blindness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Lazy eye	
Ears	<input type="checkbox"/> Deafness	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Deformities	
Nose/ Throat	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Lack of sense of smell	
Mouth	<input type="checkbox"/> Cleft palate	<input type="checkbox"/> Cleft lip		
Glands	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Diabetes (adult)	<input type="checkbox"/> Diabetes (juvenile)	
Lungs	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cystic fibrosis		
Heart	<input type="checkbox"/> Murmurs	<input type="checkbox"/> Heart attacks	<input type="checkbox"/> Congenital abnormalities	<input type="checkbox"/> High blood pressure
Stomach/ Bowel	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Colitis	<input type="checkbox"/> Lactose intolerance	
Kidney/Bladder	<input type="checkbox"/> Congenital abnormalities	<input type="checkbox"/> Infections	<input type="checkbox"/> Kidney stones	
Bone/ Joint Disease	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteogenesis imperfecta	
Neurological Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Strokes	
Psychiatric	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Manic depressive (bipolar disorder)		
Cancer Type				
Developmental Problems				
Other Probems				

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Surgical History

Patient Name: _____ D.O.B.: _____

General Surgery

<input type="checkbox"/> Inguinal hernia repair	<input type="checkbox"/> Umbilical hernia repair
<input type="checkbox"/> Appendectomy (for appendicitis)	<input type="checkbox"/> Repair of pyloric stenosis
<input type="checkbox"/> Excision of skin lesion/cysts	<input type="checkbox"/> Foreign body removal (airway, GI tract, ear, nose)

Gastrointestinal Surgery

<input type="checkbox"/> Ladd's procedure (for malrotation)	<input type="checkbox"/> Fundoplication (for GERD)
<input type="checkbox"/> Bowel resection	<input type="checkbox"/> Anorectal malformation repair
<input type="checkbox"/> Colostomy/ ileostomy (creation or closure)	

Urologic Surgery

<input type="checkbox"/> Circumcision	<input type="checkbox"/> Orchidoplexy (for undescended testicle)
<input type="checkbox"/> Orchiectomy (for removal of testicle)	<input type="checkbox"/> Vesicoureteral reflux surgery
<input type="checkbox"/> Hypospadias repair	<input type="checkbox"/> Posterior urethral valve ablation

ENT Surgery

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Adenoidectomy
<input type="checkbox"/> Ear tubes	<input type="checkbox"/> Choanal atresia repair
<input type="checkbox"/> Laryngomalacia surgery	<input type="checkbox"/> Endoscopic sinus surgery

Cardiovascular Surgery

<input type="checkbox"/> Patent ductus arteriosus ligation (PDA)	<input type="checkbox"/> Atrial septal defect (ASD)
<input type="checkbox"/> Ventricular septal defect (VSD)	<input type="checkbox"/> Tetralogy of fallot repair
<input type="checkbox"/> Coarctation of the aorta repair	<input type="checkbox"/> Pectus excavatum repair

Neurosurgical Procedures

<input type="checkbox"/> Ventriculoperitoneal (VP) shunt placement for hydrocephalus	<input type="checkbox"/> Craniostomy repair
<input type="checkbox"/> Tethered cord release	<input type="checkbox"/> Myelomeningocele closure (for spina bifida)

Orthopedic Surgery

<input type="checkbox"/> Clubfoot correction	<input type="checkbox"/> Fracture repair
<input type="checkbox"/> Scoliosis surgery	<input type="checkbox"/>

Other

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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