Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

PATIENT HISTORY *(Ages 6 mos+)*

***Today's Date*: _____**

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **SEX:** ☐M ☐F

HOME & SCHOOL

Who lives at home? _____

If age appropriate does your child attend:

☐ Daycare ☐ Preschool ☐ Elementary school or higher ☐ None of the above

Name of School/Preschool/Daycare: _____

If none, who cares for your child[ren] during the day? _____

ILLNESSES

Have there been any hospitalizations?	☐ Y ☐ N
Have there been any major medical problems?	☐ Y ☐ N
Any childhood illnesses? (ex: chickenpox, measles, etc.)	☐ Y ☐ N
Fracture or other injury?	☐ Y ☐ N

If yes, please describe: _____

_____

GENERAL HEALTH

Medications: _____

Allergies: _____

Special Dietary Needs: _____

REVIEW OF SYSTEMS

Has she/he had frequent problems with any of the following *(please check and/or write in all that apply)*:

☐ **Head** Headaches, dizziness, injury, other: _____

☐ **Eyes** Vision problems, infection, pain, other: _____

☐ **Ears** Hearing problems infections, pain, other: _____

☐ **Nose** Frequent stuffiness, easy bleeding, other: _____

☐ **Mouth** Tooth decay, poor bite, other: _____

☐ **Throat** Frequent sore throat, trouble with swallowing, other: _____

☐ **Neck** Stiffness, swelling, swollen glands, other: _____

☐ **Chest** Deformity, pneumonia, cough, asthma, other: _____

☐ **Heart** Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other:

_____

☐ **Abdomen** Vomiting, frequent pain, diarrhea, constipation, other: _____

☐ **Urinary** Pain on voiding, voiding frequently, bed wetting, other: _____

☐ **Skin** Rash, infection, other: _____

☐ **Neurological** Development problems, seizures, meningitis, other: _____

☐ **Endocrine** Weight gain/loss, intolerance to heat/cold, thirst, hair changes (thinning, falling out), other:

_____

☐ **Arms & Legs** Deformity, abnormal walking, joint pain, joint swelling, other: _____

☐ **Hematological** Anemia, abnormal bleeding, other: _____