FAMILY HEALTH
ASSOCIATES

Derek T. Earl, DO, CIC | Jonas H. Oltman, DO | Shara M. Salverda, FNP | Jessica L. Oltman, FNP-C | Dawn R. Headings, FNP- BC | John R. Adair, PA-C | Maria A Faaeteete, FNP-C

PEDIATRIC MEDICAL HISTORY (ages birth – 4 years)

Patient Name: _____ Date: _____

To be completed by parent or guardian. Please answer questions to the best of your ability.

1. Has patient had an allergic reaction or intolerance to any of the following (Circle all that apply)?

No allergies Shellfish Peanuts Latex (rubber gloves) Bee Stings Eggs
No intolerances Medications: _____ Other:_____

2. Is patient taking any over the counter medications, fluoride, prescriptions or drugs?

□ **YES** □ **NO** Please describe _____

3. Are there any cultural or religious practices that might affect your child's medical care?

□ **YES** Please explain _____ □ **NO**

4. How was/is baby fed?

□ **Breast** □ **Formula**

5. Please circle any conditions or symptoms your child has or has had on the list below.

- Allergies *(seasonal, hay fever, etc….)*
- Asthma
- Autoimmune disorder
- Blood disorders
- Urinary, Kidney, Testicle problems
- Heart problems *(including murmur or high blood pressure)*
- Learning disability or special education needs
- Broken bones? Where_____
- Stomach problems
- Developmental Delay
- Cavities or tooth pain/injury
- Head injury, concussion or seizures
- Missing or damaged organs *(kidney, eye, testicle)*
- Problems since birth/Genetic disorders
- Other:_____

6. Has patient had any surgeries, major injuries, or been in the hospital overnight? □ YES □ NO

If Yes, what surgeries/injuries or why were you in the hospital? _____

_____

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PEDIATRIC MEDICAL HISTORY (ages birth – 4 years)

Patient Name: _____ Date: _____

ORAL HEALTH

7. Does patient visit the dentist regularly (at least once a year)? □ YES □ NO
When was the last visit? _____

8. Does anyone in the home smoke cigarettes: □ YES □ NO

BIRTH HISTORY

9. Where was your child born? _____

10. Was your child born more than one month early? **□ YES □ NO** _____

11. Were there problems with the pregnancy or birth? **□ YES □ NO**
If yes, what? _____

12. Did the mother smoke, use drugs, or drink alcohol during the pregnancy, including before she knew she was pregnant? **□ YES □ NO** If yes, what? _____

FAMILY MEDICAL HISTORY

Medical problems can run in families. Please circle below any health problems of the patient's family member(s).

Any relatives that have died before the age of 50? **□ YES □ NO** If yes, what was the case of death (if known)? _____

Mother (Biological): Living? □ YES □ NO □ DON'T KNOW

Has no medical problems	Diabetes	Kidney problems	Heart problems
Stroke/blood clots	Alcohol/drug abuse	High blood pressure	
Cancer: Type_____	Mental health conditions : Depression, anxiety, ADHD, bipolar disorder		
Other: _____			

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PEDIATRIC MEDICAL HISTORY (ages birth – 4 years)

Patient Name: _____ Date: _____

Father (Biological): Living? □ YES □ NO □ DON'T KNOW

Has no medical problems Diabetes Kidney problems Heart problems
Stroke/blood clots Alcohol/drug abuse High blood pressure
Cancer: Type_____ Mental health conditions : Depression, anxiety, ADHD, bipolar disorder
Other: _____

Sister(s)/Brother(s) (Biological): Living? □ YES □ NO □ DON'T KNOW

Has no medical problems Diabetes Kidney problems Heart problems
Stroke/blood clots Alcohol/drug abuse High blood pressure
Cancer: Type_____ Mental health conditions : Depression, anxiety, ADHD, bipolar disorder
Other: _____

Patient Name: _____

Patient Signature: _____ Date _____

Parent or Guardian Signature: _____ Date _____