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 5 – 11)

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. Please circle any conditions or symptoms the patient has or has had on the list below.

- Allergies *(seasonal, hay fever, etc.)*
- Asthma
- Autoimmune disorder
- Blood disorders
- Urinary, Kidney, Testicle problems
- Eating disorders *(throwing up, not eating, or eating too much)*
- Heart problems
- High cholesterol
- Learning disability or special education needs
- Chest pain, difficulty breathing, coughing or wheezing with exercise
- Mental health condition *(anxiety, ADHD, depression, etc.)*
- Broken bones? Where_____
- Autism Spectrum Disorder
- Developmental delay
- Stomach problems Type: _____
- Cavities, tooth pain or injury
- Dizziness, fainting, or heat related illness
- Headaches or migraines
- Head injury, concussion or seizures
- Missing or damaged organs *(kidney, eye,*
- *testicle)* Which? _____
- Problems since birth, genetic disorders
- Cancer - Type:_____

Other:_____

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

If yes, please explain _____

_____

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PEDIATRIC MEDICAL HISTORY (ages 5 – 11)

Patient Name: _____ Date: _____

BIRTH HISTORY

6. Where was your child born? _____

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

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

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

ORAL HEALTH

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

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

FAMILY MEDICAL HISTORY

Medical problems can run in families. Please circle below to tell us about any health problems of your child's family members.

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 5 – 11)

FAMILY MEDICAL HISTORY, continued

Medical problems can run in families. Please circle below to tell us about any health problems of your child's family members.

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: _____ Date: _____

Patient Signature: _____

Parent/ Guardian Signature: _____