FAMILY HEALTH
ASSOCIATES

Derek T. Earl, DO, CIC | Jonas H. Oltman, DO | Patrick B. Johansing, 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 | Jadie A. Dolan, FNP-C

PEDIATRIC MEDICAL HISTORY (AGES 5-11)

Patient Name: _____ **Date:**_____

To be completed by adolescent, parent or guardian. If parent or guardian is completing, please answer questions about your child's health history. Skip any questions that you do not know the answer to.

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

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

2. Is your child taking any health supplements, fluoride, medications (including non-prescription)?
☐ Yes ☐ No Please list _____

3. Please check any conditions or symptoms the patient has or has had on the list below:

☐ Asthma
☐ Allergies (seasonal, hay fever, etc)
☐ Autoimmune disorders
☐ Blood disorders
☐ Urinary, kidney, testicle problems
☐ Problems since birth/Genetic disorders
☐ High cholesterol
☐ Learning disability or special needs
☐ Developmental delay
☐ Broken bones? Where: _____
☐ Cavities or tooth pain/injury
☐ Dizziness, fainting, or heat related illness
☐ Headaches/migraines
☐ Head injury, concussion or seizures
☐ Missing or damaged organs (kidney, eye, testicle)
☐ Cancer type: _____
☐ Other: _____
☐ Autism spectrum disorder
☐ Stomach problems
☐Problems with your period
☐ Mental health condition (ADHD, depression, anxiety, etc)
☐Heart problems (including murmur or high blood pressure)
☐ Chest pain, difficulty breathing, coughing or wheezing with exercise
☐Is there any reason why adolescent should not participate in sports or has ever been refused to participation for a medical reason? ☐ Yes ☐ No

4. Has your child had any surgeries, major injuries, or been in the hospital overnight? ☐ Yes ☐ No
If yes, what surgeries/injuries or why were they in the hospital? _____

BIRTH HISTORY

5. What city/country was your child born in _____

6. Was your child born more than one month early? ☐Yes ☐No

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PEDIATRIC MEDICAL HISTORY (AGES 5-11) cont.

7. Were there problems with the pregnancy or birth? ☐Yes ☐No

8. 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 that can run in families. Please circle below to tell us about any health problems your family member has had.

Mother (Biological): Living YES/ NO/ I DON'T KNOW

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

Other: _____

Father (Biological): Living YES/ NO/ I DON'T KNOW

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

Other: _____

Sister/Brother (Biological): Living YES/ NO/ I DON'T KNOW

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

Other: _____

Parent/Guardian Signature:_____