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
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PEDIATRIC MEDICAL HISTORY (AGES Birth-4 Years)

Patient Name: _____ **Date:**_____

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

1. **Has patient had an allergic reaction or intolerances 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 your child taking any over the counter medications, fluoride, prescriptions or drugs?**
   ☐ Yes ☐ No Please list:_____

3. **Are there any cultural or religious practices that might affect your child's medical care?**
   ☐ Yes ☐ No Please explain:_____

4. **How was/is baby fed?** ☐ Breast ☐ Formula

5. **Please check any conditions or symptoms the patient has or has had on the list below:**
   ☐ Allergies (seasonal, hay fever, etc) ☐Cavities or tooth pain/injury
   ☐ Asthma ☐ Head injury, concussion or seizures
   ☐ Autoimmune disorder ☐ Missing or damaged organs (kidney, eye, testicle)
   ☐ Blood disorder ☐ Problem since birth/Genetic disorders
   ☐ Urinary, kidney, testicle problems ☐ Heart problems (including murmur or high blood pressure)
   ☐ Broken bones? Where _____ ☐ Problems since birth/Genetic disorders
   ☐ Learning disability or special education needs
   ☐ Other_____

6. **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

7. **What city/country was your child born in** _____

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

9. **Were there problems with the pregnancy or birth?** ☐Yes ☐No
   If yes, please describe: _____

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PEDIATRIC MEDICAL HISTORY (AGES Birth-4) Continued:

10. 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:_____