DATE: _____
OFFICE: _____

IRVING PEDIATRICS

IRVING PEDIATRICS MEDICAL HISTORY FORM

(THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

NAME OF PERSON COMPLETING THIS FORM: _____

YOUR RELATIONSHIP TO CHILD: _____ **CHILD'S PREVIOUS DOCTOR:** _____

ALLERGIES or REACTIONS TO MEDICATIONS / FOODS / OTHER AGENTS:

Medication / Allergen	Reaction or Side Effect

MEDICATIONS: List all prescription / non-prescription medicines, vitamins, home remedies, birth control pill, herbs, etc.

Medication	Dose	Times per Day	Medication	Dose	Times per Day

BIRTH HISTORY:

Where was your child born? _____ Is the child yours by: □birth □adoption □stepchild □other
Please indicate any medical problems during pregnancy: _____
Delivery by: □vaginal birth □Caesarean section (Reason for C-section: _____)
Birth weight: _____ Birth length: _____ APGAR score: 1 min _____5 min _____
Please indicate any medical problems during the newborn period: _____
_____
Other problems: _____

PAST MEDICAL HISTORY:

Are your child's immunizations up to date for their age? □ Yes □ No
Describe any major medical problems and their dates: _____
_____
_____
_____
Has your child had any of the following illnesses? □chicken pox □measles □mumps □meningitis □tuberculosis (TB)
Hospitalizations (list dates and reasons): _____
_____
_____

SURGICAL HISTORY: Please list all prior operations and dates.

Operation	Date	Reason for Operation

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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FAMILY HISTORY: Please indicate with a check mark any family members who have had any of the following conditions.

Medical Condition	Mom	Dad	Sibling	Gma	Gpa	Medical Condition	Mom	Dad	Sibling	Gma	Gpa
Alcoholism						Genetic diseases					
Anemia						Glaucoma					
Anesthesia Problem						Hay fever / allergies					
Arthritis						Hearing problems					
Asthma						Heart disease					
Birth defects						High cholesterol					
Bleeding problem						Hypertension					
Cancer, breast						Kidney disease					
Cancer, colon						Lupus					
Cancer, lung						Mental retardation					
Cancer, melanoma						Migraine headache					
Cancer, ovary						Mitral valve prolapse					
Cancer, prostate						Osteoarthritis					
Cancer, other						Osteoporosis					
Depression						Psychiatric diseases					
Diabetes, Type 1 (child onset)						Rheumatoid arthritis					
Diabetes, Type 2 (adult onset)						Stroke					
Eczema						Thyroid disorders					
Epilepsy (seizures)						Tuberculosis					

Other Medical Conditions: _____

_____

SOCIAL HISTORY:

EXPOSURE / HABITS:

Any concerns about lead exposure? □No □Yes
(old home, plumbing, peeling paint)
Do any household members smoke? □No □Yes

TV hours per day: _____
Computer hours per day: _____
Video game hours per day:

SCHOOL HISTORY:

Does your child attend daycare? □No □Yes
Does your child attend preschool / school? □No □Yes
Current grade level: _____
Name of school: _____
Any concerns about school performance? □No □Yes

Any concerns about relationship with:
Teachers? □No □Yes
Peers? □No □Yes
If more than 4 years old, does your child have a best friend?
□No □Yes

SPORTS / EXERCISE / HOBBIES:

Type of exercise: _____
List hobbies: _____

How often? _____ How long? _____
Any concerns? □No □Yes

SAFETY:

Do you use car seats / seatbelts consistently? □No □Yes
Does your child use a bike helmet regularly? □No □Yes
Is violence at home a concern? □No □Yes

Do you have guns in your home? □No □Yes
Other concerns? _____
_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM