

BROADLANDS FAMILY PRACTICE CENTER
 Pediatric/Adolescent Medical History

Child's Name _____ Nickname: _____ DOB: _____ Grade: _____

Mother's Name _____ Occupation: _____ Phone # _____

Father's Name _____ Occupation: _____ Phone # _____

Are the child's parents Married Unmarried Separated Divorced

Are there any siblings at home? YES NO Please list ages: _____

This child lives with Mother & Father Mother Only Father Only Other: _____

Is there anyone else that lives at home with this child? _____

Does your child attend daycare? _____ Primary language spoken at home _____

Who takes care of the child during the day or after school? _____

Child's Health History

Birth weight? _____ Please circle: Term Pre-term Post term

Is child adopted? YES NO

Complications with pregnancy? YES NO

Hospitalizations immediately after birth? YES NO

Has child missed any immunizations? YES NO

Has your child ever had surgery? YES NO

Other hospitalizations? YES NO

Any problems with recurring illnesses? YES NO

Any hearing, vision or other disabilities? YES NO

Any concerns about your child's development? YES NO

Any concerns about your child's behavior? YES NO

Has your child ever been seen by a specialist? YES NO

If yes to any of the above questions, please explain _____

Does your child have any **ALLERGIES** to any medications, foods, or other materials? YES NO

If yes, to what? _____

List all **medications** your child takes (include over the counter meds, vitamins and inhalers)

NAME/DOSE OF MEDICATION	REASON FOR TAKING MEDICATION

FAMILY HISTORY

Does anyone in the family have any history of the following?

Please list mother, father, maternal/paternal grandmother/grandfather, sibling

High blood pressure	YES	NO	WHO? _____
High cholesterol	YES	NO	WHO? _____
Heart disease	YES	NO	WHO? _____
Stroke	YES	NO	WHO? _____
Diabetes	YES	NO	WHO? _____
Thyroid disease	YES	NO	WHO? _____
Cancer	YES	NO	WHO? _____
Bleeding/clotting disorder	YES	NO	WHO? _____
Allergies	YES	NO	WHO? _____
Asthma	YES	NO	WHO? _____
Liver disease	YES	NO	WHO? _____
Kidney disease	YES	NO	WHO? _____
Seizures	YES	NO	WHO? _____
Migraines	YES	NO	WHO? _____
Acid reflux	YES	NO	WHO? _____
Gastrointestinal disease	YES	NO	WHO? _____
Mental problems	YES	NO	WHO? _____
Alcohol problems	YES	NO	WHO? _____
Drug problems	YES	NO	WHO? _____
Genetic disorders/Birth defects	YES	NO	WHO? _____
Autism	YES	NO	WHO? _____

Safety/Prevention

Does your child wear a seat belt?	YES	NO	
Does your child use a car seat?	YES	NO	N/A
Does your child sit in the back seat?	YES	NO	
Does your child wear protective headgear during certain activities?	YES	NO	
Does your child receive regular dental care?	YES	NO	
Do you have working smoke detectors at home?	YES	NO	
Are there any firearms in the home?	YES	NO	
Is violence at home a concern?	YES	NO	
Is your child exposed to any second-hand smoke?	YES	NO	
Are there any pets at home?	YES	NO	
Do you have any other concerns about your child?	_____		

