Anderson Integrative Medicine, PLLC
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PEDIATRIC MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____/_____/_____
Parent/Guardian Signature: _____ Date: _____/_____/_____

Present Health Concerns:
_____

MEDICATIONS: *Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergies	Reaction or Side Affect

***** If you are on 3 or more medications – please bring them with you to each appointment. *****

PERSONAL MEDICAL HISTORY: *Please indicate whether the patient has had any of the following medical problems.*

- ☐ Asthma
- ☐ Anemia
- ☐ Pneumonia
- ☐ Diarrhea
- Hearing Problems
- ☐ Heart Disease
- ☐ Ear Infections
- ☐ Convulsions/Epilepsy
- ☐ Constipation
- ☐ Rheumatic Fever
- ☐ Vision Problems
- ☐ Hay Fever
- ☐ Other: _____
  _____
  _____
- ☐

HOSPITALIZATIONS: *Please list all prior hospitalizations and dates.*

Reason	Date

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IMMUNIZATIONS: *Please list immunizations that the patient has received at other health care facilities and include your best estimate of the month and year of each immunization.*

Hepatitis A: _____ Measles: _____ Mumps: _____ Rubella: _____ MMR: _____
Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Other: _____

COMMUNICABLE DISEASES:
Has the patient ever had any of the following communicable disease(s)?

☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

PREGNANCY & BIRTH:
Is the patient yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____
Were there any medical problems during pregnancy: ☐ Yes ☐ No
If yes, please explain: _____
_____
Were there any medical problems during labor and delivery: ☐ Yes ☐ No
If yes, please explain: _____
_____
Were there any problems such as needing oxygen, trouble breathing, jaundice, etc. after patient's birth?: ☐ Yes ☐ No
If yes, please explain: _____
_____
Where was the patient born? _____ Method of Delivery: ☐ Vaginal ☐ Cesarean
Birth Weight/Length: _____lbs. _____oz. _____inches.
Was your child born prematurely? ☐ Yes ☐ No If yes, how early? _____
For Male Patients Only: Is your child circumcised? ☐ Yes ☐ No

SLEEP:
How many hours a night does the patient sleep? _____
How many naps does the patient take per day? _____ Length of naps? _____
Does the patient have any sleep problems? : ☐ Yes ☐ No
If yes, please explain: _____

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NUTRITION & FEEDING:

Type of feeding when the patient was a newborn (check all that apply): ☐ Breastfed ☐ Formula
If breastfed, for how long? _____
Has the patient had any feeding/dietary problems or restrictions?: ☐ Yes ☐ No
If yes, please explain: _____
Milk Intake now? ☐ Cow's Milk ☐ Soy Milk ☐ Coconut Milk ☐ Almond Milk ☐ Other_____
Has the patient seen a dentist? ☐ Yes ☐ No If yes, date of last visit _____.
What is the water source at the house? ☐ City ☐ Well

DEVELOPMENT:

At what age did the patient: Sit Alone _____ Walk Alone _____ Say Words _____
Toilet Train (Daytime) _____ Toilet Train (Nighttime) _____
Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themself, or feeding themself? ☐ Yes ☐ No
If yes, please explain: _____
Are there any concerns about language or speech development? ☐ Yes ☐ No
If yes, please explain: _____
When the patient is in the car, do they use: ☐ Infant Seat ☐ Booster Seat ☐ Seatbelt Only
Does the patient wear a helmet while riding a bike? ☐ Yes ☐ No
Do you have concerns about the patient's behavior at home? ☐ Yes ☐ No
If yes, please explain: _____
Do you have concerns about the patient's behavior at school? ☐ Yes ☐ No
If yes, please explain: _____
Do you have concerns about the patient's behavior in groups with other chiildren? ☐ Yes ☐ No
If yes, please explain: _____
For Female Patients Only: Age at first menstrual period _____

SOCIAL HISTORY:

Are the patient's parents: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced
If separated or divorced, for how long? _____
Mother's Employer: _____ Mother's Occupation: _____
Father's Employer: _____ Father's Occupation: _____
Do any household members smoke? ☐ Yes ☐ No
Is violence in the home a concern? ☐ Yes ☐ No Are there guns in the home? ☐ Yes ☐ No
Would you like to speak with the provider regarding the patient's: ☐ Alcohol Use ☐ Tobacco Use ☐ Sexual Activity ☐ Aggressive Behavior
How many hours per day does the patient spend with the following: ____ Watching TV ____ On the Computer/iPad _____ Playing Video Games
Do you have any concerns about lead exposure due to having an old home, or because of plumbing or peeling paint? ☐ Yes ☐ No

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Who lives at home with the patient?

NAME	AGE	RELATIONSHIP	HIGHLEST LEVEL OF EDUCATION

SCHOOL HISTORY:

Did/Does the patient attend school/preschool? ☐ Yes ☐ No ☐ Current grade in school? _____
Do you have concerns with how the patient is doing in school? ☐ Yes ☐ No
If yes, please explain: _____
Any concerns about relationships with teachers or other students? ☐ Yes ☐ No
If yes, please explain: _____
If more than 4 years old: does your child have a best friend? ☐ Yes ☐ No
Does your child play any sports: ☐ Yes ☐ No
If yes please list the sports/activities: _____
How many times a week? _____ How long (minutes)? _____

FAMILY HISTORY: *Please indicate with a check (√) who in the patient's family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	LIVING STATUS	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Depression
MOTHER									
FATHER									
SIBLINGS									
MATERNAL GRANMOTHER									
MATERNAL GRANDFATHER									
PATERNAL GRANDMOTHER									
PATERNAL GRANDFATHER									
OTHER FAMILY MEMBERS: _____ _____ _____									

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REVIEW OF SYSTEMS: *Please indicate with a check* (√) *any current problems your child has on the list below.*

CONSTITUTIONAL
- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss
- ☐ Fatigue/weakness
- ☐ Excessive thirst or urination

EYES
- ☐ Change in vision
- ☐ Nearsighted
- ☐ Farsighted

EARS/NOSE/THROAT/MOUTH
- ☐ Difficulty hearing/ringing
- ☐ Hay fever/allergies
- ☐ Problems with teeth/gums

CARDIOVASCULAR
- ☐ Chest pain/discomfort
- ☐ Leg pain with exercise
- ☐ Palpitations

CHEST (BREAST)
- ☐ Breast lump/discharge

RESPIRATORY
- ☐ Cough/wheeze
- ☐ Difficulty breathing

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

GENITOURINARY
- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Sexual function problems
- ☐ Discharge from penis

MUSCULO-SKELETAL
- ☐ Muscle/joint pain

NEUROLOGICAL
- ☐ Headaches
- ☐ Dizziness/light-headedness
- ☐ Numbness
- ☐ Memory Loss
- ☐ Loss of coordination
- ☐ Autism Spectrum Disorder
- ☐ ADD/ADHD
- ☐ Sensory Processing Issues
- ☐ Learning Delays/Dyslexia
- ☐ Social/Emotional Delays
- ☐ Developmental Delays

GYNECOLOGICAL
- ☐ Abnormal vaginal bleeding
- ☐ Problems with conception
- ☐ Problems with contraception
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Painful intercourse

PSYCHIATRIC
- ☐ Anxiety/stress
- ☐ Depression
- ☐ Problems with sleep
- ☐ Self-Harm
- ☐ Problems with sleep
- ☐ Other: _____

_____

_____

Is there anything else about the patient that we should know? _____

_____

_____

_____

_____

_____

_____

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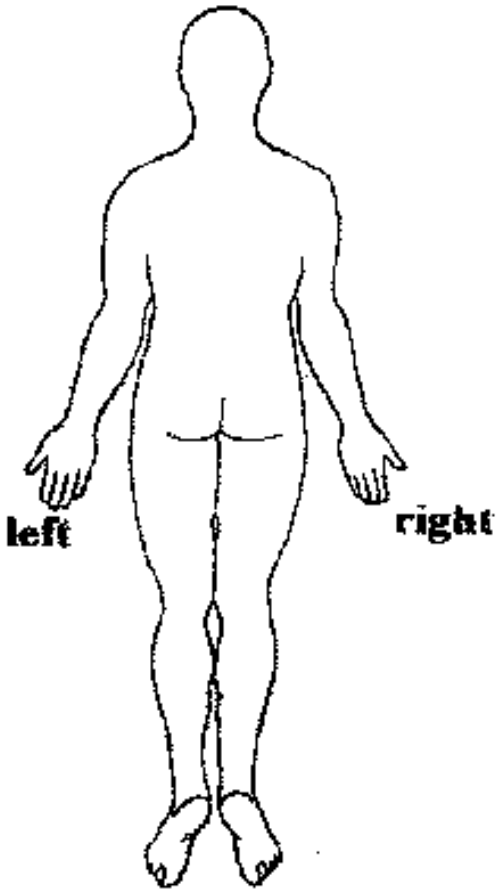
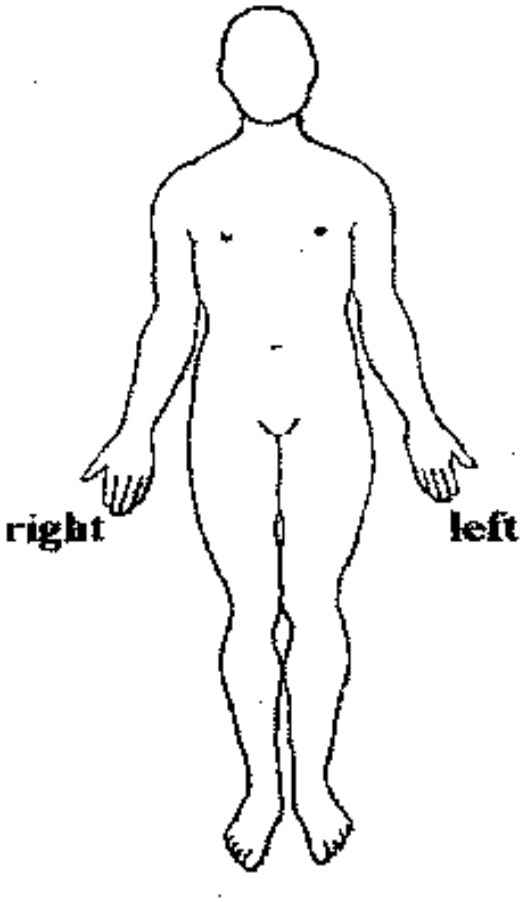
Pain Diagram

Name _____ Date _____

Draw the location of your pain on the body outlines below. Use the appropriate colored pencil (or letter code) to denote the kind of pain you are having now. Using a pen, draw all scars that are on your body.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER	SCARS(++)
Brown	Red	Blue	Orange	Green	Yellow	Pen (ink)
Or A	B	N	P	S	O	





No pain (----------) Worse possible pain

Please mark on the pain line what you feel your average pain is.