Riverview PEDIATRICS

Medical History

Patient Name: _____ **DOB:** _____

Personal Medical History:

Has your child ever been involved in a serious injury or accident? □ No □ Yes
If yes, when and why? _____

Has your child ever had surgery? □ No □ Yes
If yes, when and what procedure? _____

_____

Has your child ever stayed overnight in a hospital? □ No □ Yes
If yes, when and why? _____

_____

Please check if your child has had any of the following medical problems:

- □ ADD/ADHD
- □ Allergies/sinus problems:
  - □ Animal Allergens
  - □ Outdoor Allergens
  - □ Indoor Allergens
- □ Anemia or Bleeding Problems
- □ Blood Transfusion
- □ Mental Health Concerns
  - □ Anxiety
  - □ Depression
  - □ Other diagnosis _____
- □ Wheezing, Asthma, RSV, Bronchiolitis, Pneumonia, or Croup (any nebulizer/inhaler use?)
- □ Autism (spectrum disorder)
- □ Bed-wetting (after 5 yrs. of age)
- □ Cancer
- □ Chicken Pox
- □ Congenital anomalies (defect born with)
- □ Constipation requiring doctor visits
- □ Developmental Delays
- □ Behavior Problems/Disorders
- □ Diabetes
- □ Ear Infections or Ear Tubes
- □ Problems with Ears or Hearing
- □ Head injury/concussion
- □ Frequent Headaches
- □ Heart Problems or Heart Murmur
- □ Urinary Tract Infections
- □ Kidney Problems
- □ Orthopedic Concerns (Muscle, joint or bone problems)
- □ Nasal Polyps
- □ All previous doctors/pediatricians _____ _____
- □ Seizures/Epilepsy
- □ Sickle Cell Trait/Disease
- □ Chronic or Recurrent Skin Problems (Acne, Eczema, etc.)
- □ Thyroid or other Endocrine Problems
- □ Any Eye/Vision Conditions
- □ Wear glasses or corrective Lenses
- □ Pharyngitis/Tonsillitis
- □ Other Infectious Illnesses
- □ Abdominal Pain/ Reflux
- □ If Female and menstrual periods have started, any problems with periods?

Medical History

Social History:
Who lives at home? (Including pets)

_____

Does anyone in your home smoke?	□ No	□ Yes
Are there any guns in the home?	□ No	□ Yes
If yes, are guns locked and kept separate from ammunition?	□ No	□ Yes
Smoke / CO detectors in home?	□ No	□ Yes
Car Seat/Booster seat/seat belt used routinely?	□ No	□ Yes
Sunscreen used routinely?	□ No	□ Yes
Insect repellant used routinely when necessary?	□ No	□ Yes

School name and what grade?

_____

Well Water or City Water (fluoride in water?) _____ □ No □ Yes

Recent changes in family / social situation?

_____

Diet: eat 2-3 servings of fruits/vegetables per day □ No □ Yes

Drink any pop or soda? If yes, how many times a week?

_____

Family Medical History:

Please check mark if your child has a family history of any of the following:

Diagnosis	Biological Mother	Biological Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other:
Allergies									
Asthma/ Lung Disease									
Heart Disease/ Condition									
High Blood Pressure									
High Cholesterol									
Diabetes or Other Endocrine Problems									
Cancer, what type?									
Anemia									

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Diagnosis	Biological Mother	Biological Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other:
Bleeding Disorders									
Seizures/epilepsy									
Developmental Disorders									
Neurological Disorders (including ADD/ ADHD)									
Liver Disease									
Other GI Disease/ Disorder									
Kidney Disease									
Bed-wetting (after 10 yrs of age)									
Hearing Impairment									
Eye Disorder									
Immune Problems, or HIV/AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Obesity									
Other									