PeninsulaResearchAssociates

Leading Medical Research for a Healthy Tomorrow

PEDIATRIC MEDICAL HISTORY FORM

PERSONAL INFORMATION

Child's Name:	**Date of Birth:**	**Age:**	**Sex:**
Ethnicity: ☐African American ☐American Indian ☐Asian/Pacific Islander ☐Caucasian ☐Hispanic/Latino ☐Multi-Racial: _____ *(please specify)*			
Address:	**City:**	**State:**	**Zip Code:**
Home Phone: ☐N/A	**Email:** ☐N/A		
Name of Parent/Guardian(s):			
Home Phone: ☐N/A	Cell Phone: ☐N/A		
Name of Parent/Guardian(s):			
Home Phone: ☐N/A	Cell Phone: ☐N/A		
Emergency Contact 1:	Contact Number:	Relation:	
Does your child see a primary physician? ☐Yes ☐No			
Physician Name:	Phone Number: Fax Number:		
Immunizations: Please bring your child's immunization records to your appointment.			
Has your child started their menses? ☐Yes ☐No ☐NA-Male			

ALLERGY INFORMATION

Is your child allergic to any medications?		☐Yes ☐No	
Medication		**Start Date**	**Stop Date/Ongoing**
Type:_____	☐Yes ☐No		
Type: _____	☐Yes ☐No		
Is your child allergic to any foods?		☐Yes ☐No	
Food		**Start Date**	**Stop Date/Ongoing**
Food: _____	☐Yes ☐No		
Food: _____	☐Yes ☐No		
Food: _____	☐Yes ☐No		
Food: _____	☐Yes ☐No		

Completing Individual's Initials & Date: _____

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CHILD'S MEDICAL HISTORY

CARDIOVASCULAR			**Start Date**	**Stop Date/Ongoing**
High Blood Pressure	☐Yes	☐No		
Heart Murmur	☐Yes	☐No		
Irregular Heartbeat	☐Yes	☐No		
STOMACH/DIGESTIVE			**Start Date**	**Stop Date/Ongoing**
Constipation requiring doctor visits	☐Yes	☐No		
GERD	☐Yes	☐No		
Liver Disease	☐Yes	☐No		
MUSCULOSKELETAL			**Start Date**	**Stop Date/Ongoing**
Bone Fractures:_____ *(location)*	☐Yes	☐No		
Bone Fractures:_____ *(location)*	☐Yes	☐No		
Scoliosis	☐Yes	☐No		
RESPIRATORY/LUNG			**Start Date**	**Stop Date/Ongoing**
Asthma	☐Yes	☐No		
Bronchitis	☐Yes	☐No		
Pneumonia	☐Yes	☐No		
Tuberculosis	☐Yes	☐No		
Measles	☐Yes	☐No		
DERMATOLOGICAL/SKIN			**Start Date**	**Stop Date/Ongoing**
Eczema	☐Yes	☐No		
Chronic Hives/Idiopathic Urticaria	☐Yes	☐No		
Psoriasis	☐Yes	☐No		
MRSA	☐Yes	☐No		
Other:_____	☐Yes	☐No		
HEMATOLOGICAL/BLOOD			**Start Date**	**Stop Date/Ongoing**
Anemia	☐Yes	☐No		
AIDS/HIV	☐Yes	☐No		
Blood Transfusion	☐Yes	☐No		
Jaundice	☐Yes	☐No		
GENITOURINARY			**Start Date**	**Stop Date/Ongoing**
Chronic Urinary Tract Infections	☐Yes	☐No		
Kidney Disease	☐Yes	☐No		
Other:_____	☐Yes	☐No		
ENDOCRINE/METABOLIC			**Start Date**	**Stop Date/Ongoing**
Diabetes ☐Type I ☐Type II	☐Yes	☐No		
Thyroid Disease	☐Yes	☐No		
Obesity	☐Yes	☐No		
Growth Delay	☐Yes	☐No		
NERVOUS/NEUROLOGICAL/PSYCHIATRIC			**Start Date**	**Stop Date/Ongoing**
Depression	☐Yes	☐No		
Anxiety Disorder	☐Yes	☐No		
Bipolar Disorder	☐Yes	☐No		
Insomnia	☐Yes	☐No		
☐ADHD ☐ADD	☐Yes	☐No		
Autism/Autistic Spectrum Disorder	☐Yes	☐No		
Seizures or Convulsions	☐Yes	☐No		

Completing Individual's Initials & Date: _____

CHILD'S MEDICAL HISTORY Cont'd

NERVOUS/NEUROLOGICAL/PSYCHIATRIC			Start Date	Stop Date/Ongoing
Frequent Headaches	☐Yes	☐No		
Frequent Migraines	☐Yes	☐No		
Developmental Delay	☐Yes	☐No		
Meningitis	☐Yes	☐No		
EAR, EYE, NOSE, THROAT			**Start Date**	**Stop Date/Ongoing**
Allergic Rhinitis/Environmental Allergies	☐Yes	☐No		
Chronic Sinusitis	☐Yes	☐No		
Nasal Polyps	☐Yes	☐No		
Nearsighted:	☐Yes	☐No		
Farsighted:	☐Yes	☐No		
OTHER			**Start Date**	**Stop Date/Ongoing**
Cancer:_____	☐Yes	☐No		
Immunotherapy/Allergy Shots	☐Yes	☐No		
Other:_____	☐Yes	☐No		
Other:_____	☐Yes	☐No		
Other: _____	☐Yes	☐No		

SURGERIES/HOSPITALIZATIONS/ER VISITS

Please list ALL of your child's previous and planned SURGERIES, HOSPITALIZATIONS, and ER VISITS	
Name/Event:	**Date:**

CURRENT MEDICATIONS

Please list all your child's medications (prescribed or over-the-counter), vitamins, and supplements the patient is currently taking.

NAME	DOSE	FREQUENCY	START DATE	STOP DATE
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing
				☐ Ongoing

I confirm that to the best of my knowledge the above information is accurate.

Completing Individual's Printed Name: _____ Relationship to patient: _____

Completing Individual's Signature: _____ Date: _____