JORDAN VALLEY COMMUNITY HEALTH CENTER

Name _____ Date of Birth ____ / ____ / _____

## Pediatric Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

| | | | | | |
|---|---|---|---|---|---|
| ❑ ADD / ADHD | ____/____/____ | ❑ Cystic fibrosis | ____/____/____ | ❑ Cognitively & Developmentally Disabled | ____/____/____ |
| ❑ Abdominal Pain | ____/____/____ | ❑ Dizziness/Fainting spells | ____/____/____ | | |
| ❑ Acne | ____/____/____ | ❑ Diabetes | ____/____/____ | | |
| ❑ Allergic Rhinitis | ____/____/____ | ❑ Depression | ____/____/____ | ❑ Menstrual problems | ____/____/____ |
| ❑ Allergies | ____/____/____ | ❑ Down's syndrome | ____/____/____ | ❑ Migraine headaches | ____/____/____ |
| ❑ Anemia | ____/____/____ | ❑ Eczema | ____/____/____ | ❑ Mitral valve prolapsed | ____/____/____ |
| ❑ Anxiety | ____/____/____ | ❑ Fracture | ____/____/____ | ❑ Jaw pain | ____/____/____ |
| ❑ Artificial heart valve | ____/____/____ | Location: _____ | | ❑ Pneumonia | ____/____/____ |
| ❑ Asthma | ____/____/____ | ❑ Headaches | ____/____/____ | ❑ Prematurity | ____/____/____ |
| ❑ Autism | ____/____/____ | ❑ Hearing problems | ____/____/____ | ❑ Recurrent ear infections | ____/____/____ |
| ❑ Bronchiolitis | ____/____/____ | ❑ Heartburn | ____/____/____ | ❑ Seizure disorder | ____/____/____ |
| ❑ Bronchitis | ____/____/____ | ❑ Hemophilia | ____/____/____ | ❑ Seizures – febrile | ____/____/____ |
| ❑ Bruise easily / Excessive bleeding | ____/____/____ | ❑ Heart attack | ____/____/____ | ❑ Sinus trouble | ____/____/____ |
| | | ❑ Heart murmur | ____/____/____ | ❑ Spina bifida | ____/____/____ |
| ❑ Cancer Type: _____ | ____/____/____ | ❑ Heart trouble / disease | ____/____/____ | ❑ Taken Phen-Fen or Redux | ____/____/____ |
| | | ❑ Hepatitis Type: _____ | ____/____/____ | | |
| ❑ Chemotherapy / Radiation Treatment | ____/____/____ | | | ❑ Tuberculosis | ____/____/____ |
| | | ❑ Herpes | ____/____/____ | ❑ Bladder infections | ____/____/____ |
| ❑ Chickenpox | ____/____/____ | ❑ HIV | ____/____/____ | ❑ MRSA infection | ____/____/____ |
| ❑ Cold sores / Fever blisters | ____/____/____ | ❑ High blood pressure | ____/____/____ | | |
| ❑ Concussion | ____/____/____ | ❑ Irregular heart beat | ____/____/____ | Other: | |
| ❑ Constipation | ____/____/____ | ❑ Kidney disease | ____/____/____ | _____ | ____/____/____ |
| ❑ Convulsions / Epilepsy | ____/____/____ | ❑ Vision problems | ____/____/____ | _____ | ____/____/____ |
| ❑ Cortisone medicine | ____/____/____ | ❑ Stroke | ____/____/____ | _____ | ____/____/____ |

## Surgical History

Please check all that apply.

| | Date | | Date | | Date |
|---|---|---|---|---|---|
| ❑ Appendix removed | _____ | ❑ Adenoid removed | _____ | Other: | |
| ❑ Hernia repair | _____ | ❑ Ear tubes | _____ | _____ | _____ |
| ❑ Fracture with surgery | _____ | ❑ Circumcision | _____ | _____ | _____ |
| ❑ Dental surgery | _____ | ❑ Eye surgery | _____ | _____ | _____ |
| ❑ Tonsils removed | _____ | | | | |

## Medications

**Medication** ❑ No medications

| | |
|---|---|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

## Allergies

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

## Birth History

| | | | | | |
|---|---|---|---|---|---|
| Prenatal care given | ❑ Yes ❑ No | Feeding history | ❑ Breast | ❑ Bottle | ❑ Both |
| Maternal illness / complications | ❑ Yes ❑ No | Hep B vaccine | ❑ Yes | ❑ No | |
| Type: _____ | | Hearing test | ❑ Pass | ❑ Fail | |
| Type of delivery | _____ | Jaundice | ❑ Yes | ❑ No | |
| Birth weight | ____lbs ____oz | Oxygen required | ❑ Yes | ❑ No | |
| Stayed in NICU | ❑ Yes ❑ No | | | | |

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## Pediatric Family History

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death.

| ❑ Adopted | Mother | Father | Brother | Sister | Grandparents | Children | Cause of Death |
|---|---|---|---|---|---|---|---|
| ❑ ADD/ADHD | | | | | | | |
| ❑ Allergies | | | | | | | |
| ❑ Asthma | | | | | | | |
| ❑ Birth defects | | | | | | | |
| ❑ Heart disease | | | | | | | |
| ❑ Cancer | | | | | | | |
| Type: _____ | | | | | | | |
| ❑ Heart disease | | | | | | | |
| ❑ DDH (hip dysplasia) | | | | | | | |
| ❑ Deafness | | | | | | | |
| ❑ Depression | | | | | | | |
| ❑ Developmental delay | | | | | | | |
| ❑ Diabetes | | | | | | | |
| ❑ Skin disorder | | | | | | | |
| ❑ Genetic disorder | | | | | | | |
| ❑ High cholesterol | | | | | | | |
| ❑ High blood pressure | | | | | | | |
| ❑ Learning disability | | | | | | | |
| ❑ Mental retardation | | | | | | | |
| ❑ Migraine headaches | | | | | | | |
| ❑ Obesity | | | | | | | |
| ❑ Scoliosis | | | | | | | |
| ❑ Seizures / epilepsy | | | | | | | |
| ❑ Sudden Infant Death Syndrome | | | | | | | |
| ❑ Crossing of eyes | | | | | | | |
| ❑ Thyroid Disease | | | | | | | |
| Other: _____ | | | | | | | |
| Other: _____ | | | | | | | |

## Education

School Name: _____ ❑ Learning disability

Grade in school: _____

## Social History

Resides With: _____

Child Care: _____

Smokers at home? ❑ Yes ❑ No

Hand Dominance ❑ Right ❑ Left

Cooperates with family/friends ❑ Yes ❑ No

Cooperates with teachers ❑ Yes ❑ No

Has enough friends ❑ Yes ❑ No

Concerns about relationship with family/friends/others ❑ Yes ❑ No

Water source ❑ Municipal ❑ Well

Is water fluoridated? ❑ Yes ❑ No

Is there lead in home? ❑ Yes ❑ No

Home type: ❑ Apartment ❑ Condominium ❑ Duplex ❑ Single-family

Other: _____

## Lifestyle

Sleep through the night ❑ Yes ❑ No

Minimum 8.5 hrs sleep nightly ❑ Yes ❑ No

Exercise / sports _____ hours per day

TV / computer games _____ hours per day

## Safety

Uses bike / skating helmet ❑ Yes ❑ No

Pets / animals at home ❑ Yes ❑ No

Firearms in the home ❑ Yes ❑ No

Type: _____

## Drug Use Abuse

Have you ever used illegal drugs? ❑ Yes ❑ No ❑ Formerly Type _____