PediPlace

Patient Medical History

502 S. Old Orchard Lane • Lewisville, TX 75067

Phone:(972)-436-7962 Fax: (972)-353-5780

Patient Name: _____ Birth Date: _____

Medications

List all medications your child takes, prescription and nonprescription, and their dosage: ☐ No medications

Medication	Dose
1.	
2.	
3.	
4.	
5.	

Allergies

Has your child had allergic reactions to medications, foods, or insect bites? ☐ No ☐ Yes, please list them:

_____

_____

Birth History

Mother's age at birth? _____How many pregnancies?_____ How many live births?_____Miscarriages? _____

Did mother have any illness during pregnancy? ☐ No ☐ Yes, please list: _____

Did she take any medications other than vitamins and iron? ☐ No ☐ Yes, please list them:_____

How many weeks or months was this pregnancy? _____ Was this a c-section or vaginal birth? _____

What was the baby's birth weight? _____ Did the baby have any trouble starting to breath ? ☐ No ☐ Yes

Did the baby have any trouble while in the hospital (jaundice, infections, other)? ☐ No ☐ Yes, please list them:

_____

Past Medical History

Where has your child gone for checkups until now? _____

Has your child ever been in the hospital or had a surgery ? ☐ No ☐ Yes, what year?_____ for what?_____

Please indicate if your child has ever experienced any of the following conditions. Please include the date of experience.

☐ Allergies	___/___/___	☐ Diabetes Type II	___/___/___	☐ Insomnia	___/___/___
☐ Anemia	___/___/___	☐ Diarrhea	___/___/___	☐ Irritable bowel syndr.	___/___/___
☐ Anxiety	___/___/___	☐ Esophageal reflux	___/___/___	☐ Kidney disease	___/___/___
☐ Asthma	___/___/___	☐ Headache	___/___/___		
☐ Broken bones	___/___/___	☐ Heart disease	___/___/___	☐ Liver disease	___/___/___
☐ Chronic bronchitis	___/___/___	_____		☐ Skin Problems	___/___/___
☐ Constipation	___/___/___	☐ Hepatitis	___/___/___	☐ Migraines	___/___/___
☐ Chronic sinusitis	___/___/___	☐ High cholesterol	___/___/___	☐ Seizures/epilepsy	___/___/___
☐ Colitis	___/___/___	☐ Irregular heart rhythm	___/___/___	☐ Sleep apnea	___/___/___
☐ Depression	___/___/___	☐ Hypertension	___/___/___	☐ Tuberculosis	___/___/___
☐ Diabetes Type I	___/___/___	☐ Thyroid disease	___/___/___	☐ Other	___/___/___
☐ Developmental problems	___/___/___	☐ Frequent ear infections	___/___/___	_____	

Family History

Please check any diseases that this child's parents, grandparent, brothers, sisters, or aunts and uncles have had:

☐ **Adopted or Foster**

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Blood disease
- ☐ Heart disease
- ☐ Heart disease before age 50
- ☐ Cancer
  Type: _____
- ☐ Depression
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Drug problems
- ☐ Eczema
- ☐ Hearing deficiency
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Inflammatory Bowel Disease
- ☐ Kidney disease
- ☐ Learning disability
- ☐ Mental illness
- ☐ Migraines
- ☐ Obesity
- ☐ Sickle Cell Disease
- ☐ Seizures/epilepsy
- ☐ Stroke (CVA)
- ☐ Tuberculosis
- ☐ Other:
- ☐ Other:

List age, sex, and general health of brothers and sisters: _____

_____

Patient Social History

What grade is your child in? _____ What school do they attend? _____

Do you live in a private house, apartment, mobile home, other? (circle)

Does anyone in your household smoke inside or outside your home or car? ☐ No ☐ Yes

Is there a working smoke alarm on each floor of the house? ☐ No ☐ Yes

Is there any problems with the condition of your home (peeling paint, insects, rats, mice, other)? ☐ No ☐ Yes

Does your child always use a car seat/seat belt when riding in a car? ☐ No ☐ Yes

Does your child always wear a helmet when riding his/her bicycle? ☐ No ☐ Yes

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Do you have a preferred pharmacy?

Pharmacy: _____ Phone number: _____

Address: _____

I certify that all the above information is correct.

_____ _____

Print Name Signature

_____

Date