Florida Medical Clinic
Internal Medicine and Pediatrics
Pediatric Health History Form

Name: _____ DOB: _____ Gender: ☐M ☐F

Previous doctor and any Specialists_____

Primary contact number for lab results and appointment confirmation: _____

Preferred Pharmacy location and phone number:_____

PRENATAL HISTORY: complete only for patients less than two years old

Name of hospital where your child was born:_____

Is your child yours by: ☐Birth ☐Adoption ☐Stepchild ☐Other

Please indicate any complications during pregnancy or delivery: _____

Delivery by: Vaginal birth or C-Section: why? _____

Birth Weight: _____ Birth Length: _____ Hep B given? _____

Hearing screen: _____

MEDICAL HISTORY: Please list any past or current medical problems, including hospitalizations, surgeries, or procedures

_____

_____

_____

_____

MEDICATIONS: Please list all medications, including vitamins, herbals, Over-the-Counter products

Name	**Dose**	**How Often**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **allergies** and type of reaction:

_____

_____

SOCIAL HISTORY

Who does the patient live with?_____

Any pets at home? If yes, what kind? _____

Does your child attend daycare or school? _____ Name of facility:_____

What grade is your child in? _____

Any concerns at school? _____

Environmental Exposures: Does anyone at home

Smoke tobacco? ☐YES ☐NO

Drink alcohol? ☐YES ☐NO

Use Drugs? ☐YES ☐NO

Does your child exercise? _____ Type of exercise:_____ How often?_____

DENTAL HISTORY: Has your child been seen by a dentist? _____ Last appointment date:_____

DEVELOPMENTAL HISTORY: At what age did your child

Sit alone? _____ Walk alone? _____ Say words? _____ Toilet train (daytime)?_____

Girls only: Age at first menstrual period? _____

Any vision problems?_____

FAMILY HISTORY:

Has anyone in the family been diagnosed with the following? List family member(s) affected.

High Blood pressure:☐YES☐NO _____
Heart Disease: ☐YES☐NO _____
Diabetes:☐YES☐NO _____
Thyroid disease: ☐YES☐NO _____
Cystic Fibrosis: ☐YES☐NO _____
Asthma: ☐YES☐NO _____
Seizures:☐YES☐NO _____
Gastrointestinal disease:☐YES☐NO _____
Genetic disorders:☐YES☐NO _____
Cancer:☐YES☐NO _____
Bleeding disorder:☐YES☐NO _____
Other:_____

NUTRITION AND FEEDING: infants only

Is your child breastfed or bottlefed? _____ Type of formula if applicable: _____

Does your child have any feeding problems? If so, please explain: _____

Milk intake: Type: ☐ Cow's milk (Nonfat, 1% fat, 2% fat, Whole Milk); ☐ Soy Milk ☐ Rice Milk; ☐ Almond Milk

Average ounces per day (8 ounces = one cup) _____

SLEEP:

Hours per night? _____ Naps (howlong/often)? _____

Any sleep problems? If so, please describe: _____

REVIEW OF SYMPTOMS: Please check (√) any current problems your child has on the list below:

Constitutional
- ☐ Fevers/chills/excessive sweating
- ☐ Unexplained weight loss/gain

Eyes
- ☐ Squinting/cross eyes

Ears/Nose/Throat
- ☐ Unusually loud voice/hard of hearing
- ☐ Mouth breathing/snoring
- ☐ Bad Breath
- ☐ Frequent runny nose
- ☐ Problems with teeth/gums

Cardiovascular
- ☐ Tires easily with exercise
- ☐ Shortness of breath
- ☐ Fainting

Respiratory
- ☐ Cough/Wheeze
- ☐ Chest Pain/Tightness

Gastrointestinal
- ☐ Nausea/vomiting/diarrhea
- ☐ Constipation
- ☐ Blood in bowel movement

Genitourinary
- ☐ Bedwetting
- ☐ Pain with urination
- ☐ Discharge: penis or vagina

Musculoskeletal
- ☐ Muscle/joint pain

Skin
- ☐ Rashes
- ☐ Unusual moles

Allergy
- ☐ Hay Fever/itchy eyes

Blood/Lymph
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness

Psychiatric/Emotional
- ☐ Anxiety/stress
- ☐ Depression
- ☐ Nail biting/thumb sucking
- ☐ Problems with sleep/nightmares
- ☐ Speech problems
- ☐ Bad temper/ breath holding/jealousy

Other: _____

Any concerns to discuss with the doctor today?

_____

_____

_____

Parent/Guardian signature: _____ Date: _____