

PEDIATRIC HISTORY FORM AGE 15 AND UNDER

Date Prepared _____	Account # _____	Guarantor Name _____
Last Name _____ First _____ M.I. _____	Date of Birth _____ Age _____	Last First M.I.
Address _____	Social Security # _____	Address _____
Number Street		Number Street
City _____ State _____ Zip _____	Sex/Marital Status:	City _____ State _____ Zip _____
Home Phone _____	Sing. Mar. Wid. Div. H.H.	Date of Birth _____
Bus. Phone _____	Male () 0 () 1 () 2 () 3 () 4	Month Day Year
Pt. Relationship to Sub./Guar.	Female () 5 () 6 () 7 () 8 () 9	Account Bus. Phone _____
1 () Self 2 () Spouse 3 () Dep. 4 () Other	Race () Blk. () Wht. () Hisp. () Other	Emergency Contact: Name _____
	Occupation _____	Phone _____
	Employer _____	

Ins. Cat. _____ Ins. Loc. _____	LIVING IN HOME	IMMEDIATE FAMILY MEMBERS NOT LIVING IN HOME
Medicare # _____	Name Relation D.O.B.	Name Relation D.O.B.
Policy # _____	_____	_____
Group # _____	_____	_____
Person # _____ Case # _____	_____	_____

PERSONAL HEALTH HISTORY

Birth Date _____ Birth weight _____

Length _____ Apgar _____

Medical Problems at Delivery _____

Complications at Delivery _____

Neonatal Medical Problems _____

Allergies _____

Hospitalizations _____

Operations _____

Medical Illnesses _____

Additional Information _____

FAMILY HEALTH

(Note Chronic Illness, Mental Illness, Allergies, etc. or Cause of Death)

RELATION _____

Father _____

Mother _____

Brothers _____

and _____

Sisters _____

Has any relation had:	NO	YES	
Significant Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional Information _____

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Past Medical History & Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

- | | | | |
|-------------------------------|--------------------------|----------------------------------|-----------------------|
| 1. High blood pressure | 13. Bronchitis | 26. Change in bowel habits | 38. Arthritis |
| 2. Diabetes | 14. Pneumonia | 27. Unexplained weight gain/loss | 39. Low back problems |
| 3. Cancer | 15. Persistent cough | 28. Hemorrhoids | 40. Skin diseases |
| 4. Heart disease | 16. T.B. | 29. Gall bladder disease | 41. Blood disorders |
| 5. Chest pain/chest tightness | 17. Hay fever | 30. Colitis | 42. Venereal diseases |
| 6. Shortness of breath | 18. Abdominal discomfort | 31. Hepatitis or jaundice | 43. Anxiety |
| 7. Swollen ankles | 19. Indigestion | 32. Thyroid disease | 44. Depression |
| 8. Palpitations | 20. Nausea | 33. Head or neck radiation | 45. Anemia |
| 9. Lightheadedness | 21. Vomiting | 34. Headache | 46. Alcohol abuse |
| 10. Frequent urination | 22. Constipation | 35. Kidney diseases | 47. Drug abuse |
| 11. Rheumatic fever | 23. Diarrhea | 36. Kidney stones | 48. Gout |
| 12. Asthma | 24. Blood in stool | 37. Difficulty urinating | 49. _____ |
| | 25. Ulcers | | 50. _____ |
