URGENT CARE

Family and Occupational Health

19895 Detroit Road
Rocky River, Ohio 44116
440/356-5500

PEDIATRIC MEDICAL HISTORY FORM

– PLEASE PRINT –

PATIENT NAME:	NICKNAME:	DATE OF BIRTH

SOCIAL HISTORY

PARENT STATUS: ☐ Live in same household ☐ Separated ☐ Divorced ☐ Mother Deceased ☐ Father Deceased

CHILD LIVES WITH: ☐ Father ☐ Mother ☐ Grandparents ☐ Legal Guardian ☐ Other ____________

Others in household: *(names and ages)*

Brothers and Sisters: ____________

Others: ____________

FAMILY HISTORY

Check any of the following diseases which have occurred among relatives: include *ONLY* the child's grandparents, parents, brothers and sisters. (Indicate *WHO* has the problem on the line provided).

☐ Anemia ______
☐ Sickle cell disease ______
☐ TB ______
☐ High blood pressure ______
☐ Heart disease ______
☐ Cancer ______
☐ Diabetes ______
☐ Strokes ______
☐ Epilepsy or convulsions ______
☐ Mental illness ______
☐ Mental retardation ______
☐ Birth defects ______
☐ Asthma ______
☐ Eczema ______
☐ "Sinus" or "hay fever" ______
☐ Kidney disease ______
☐ Liver disease ______
☐ Stomach or intestinal disease ______
☐ Alcoholism ______
☐ Extreme overweight ______
☐ Arthritis ______
☐ Bleeding problems ______
☐ Cystic fibrosis ______
☐ HIV or AIDS ______
☐ Hemophilia ______
☐ High cholesterol ______
☐ Deafness ______
☐ Migraine H/A ______

Other: ____________

Does anyone in the home smoke? ☐ Yes ☐ No Does anyone in the home drink alcohol? ☐ Yes ☐ No

Any street drugs? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

Has child lived in or frequently visited a house with chipped or peeling paint built before 1960, or remodeled or renovated while child lives there? ☐ Yes ☐ No

CHILD'S HISTORY

Birth Weight: ________ Birth Height: ________ Premature? ☐ Yes ☐ No If yes, how many weeks? ________

☐ Yes ☐ No 1. Any problems with pregnancy, labor, delivery or newborn nursery? If yes, what? ________
☐ Yes ☐ No 2. Is your child behind on immunizations?
☐ Yes ☐ No 3. Does you child take any medications everyday?
☐ Yes ☐ No 4. Is your child allergic to any medications?
☐ Yes ☐ No 5. Has your child had any surgery?
☐ Yes ☐ No 6. Has your child ever been hospitalized?
☐ Yes ☐ No 7. Is your child allergic to any foods?
☐ Yes ☐ No 8. Has your child had any repeated illnesses?
☐ Yes ☐ No 9. Has your child been sexually or physically abused?

If **YES**, explain: ____________

____

____

REVIEW OF SYSTEMS

Has your child ever had any of the following? *(Please check)*

☐ Unexplained pain
☐ Abnormal thirst or appetite
☐ Frequent infections
☐ Loss of weight
☐ Prolonged weakness or fatigue
☐ Unexplained fevers
☐ Very "picky" eating habits
☐ Behavior problems
☐ Learning problems
☐ Trouble sleeping
☐ Slow mental or physical development
☐ Concussion or unconsciousness
☐ Fainting or other "spells"
☐ Frequent headaches
☐ Seizures or convulsions
☐ Anemia
☐ Easy bruising or prolonged bleeding
☐ Prolonged "swollen glands"
☐ Lumps and swelling
☐ Birth marks
☐ Burns
☐ Skin Disease
☐ Unexplained rash
☐ Difficulty seeing or hearing
☐ Ear disease (including more than 3 ear infections)
☐ Eye disease or injury
☐ Frequent nosebleeds
☐ Crossing eyes
☐ Prolonged runny nose or congestion
☐ Sore in the mouth or lips
☐ Severe dental problems
☐ Frequent sore throat
☐ Prolonged hoarseness
☐ Snoring or breathing problems during sleep
☐ Neck pain or swelling
☐ Breast lump, tenderness or discharge
☐ Heart disease or murmur
☐ High blood pressure
☐ Prolonged cough
☐ Shortness of breath
☐ Prolonged diarrhea
☐ Frequent constipation
☐ Frequent vomiting
☐ Blood in stool or urine
☐ Bedwetting or daytime soiling
☐ Disease or abnormality of the genital area
☐ Frequent or painful urination
☐ Irregular or painful menstruation
☐ Joint swelling or pain
☐ Leg or foot problems
☐ Limp
☐ Repeated or severe sprains
☐ Spine curvature
☐ Broken bones
☐ Asthma
☐ Hayfever
☐ Severe reaction to insect bite/sting
☐ Eczema
☐ Lead Poisoning

Other: ____________ Explain any **YES** answers: ____________

Parent/Guardian Name: ____________

Parent/Guardian Signature: ____________ Date: ________