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Today's Date: _____

Last IBJI Visit Date: _____

PEDIATRIC MEDICAL HISTORY FORM

PATIENT INFORMATION

_____
Childs Name(First) (Last) (Middle)

Age: _____ Date of Birth _____ Sex: ☐ M ☐ F

Height: _____ Weight: _____ lbs ☐ Rt or ☐ Lt Handed

PARENT/GUARDIAN INFORMATION

_____
Name

_____
Street City Zip Code

_____
Phone Email Address

REFERRING PHYSICIAN

_____
Name

_____
Street Suite

_____
City State Zip Code

_____
Phone

PRIMARY CARE PHYSICIAN (if different than Referring)

_____
Name

_____
Address

_____
Phone

BIRTH HISTORY

Birth Weight: _____ Weeks Gestation: _____ Delivery: C-Section ☐ Vaginal ☐

Please describe any pregnancy or delivery complications: _____

DEVELOPMENTAL MILESTONES

Age at which child crawled: _____ Age at which child sat unsupported: _____ Age at which child walked unassisted: _____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

_____

When did problem begin: _____/_____/_____ SYMPTOMS _____

TREATMENT Describe treatment and response for current problem _____

_____

Has there been a problem before? ☐ yes ☐ no If yes, describe problem and prior treatment: _____

_____

Have there been tests or x-rays for this problem? ☐ yes ☐ no If yes, what and where? _____

_____

Do you have a copy of the test results? ☐ yes ☐ no Did you bring them with you? ☐ yes ☐ no

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*Name:*_____ */ MR#*_____

PAST FAMILY HISTORY

Is there any useful family history relating to your child's problem? ☐ yes ☐ no

If yes, please explain: _____

Mother: _____

Father: _____

Siblings: _____

SOCIAL HISTORY:

Student ☐ yes ☐ no School _____ Grade _____ Sport _____

Tobacco use: ☐ yes ☐ no Alcohol use: ☐ yes ☐ no

Date of last menstrual period: _____

Comments/Clarifications: _____

_____

REVIEW of SYSTEMS:

Has your child ever experienced or currently have any of the following signs or symptoms? If "Yes", please describe:

Ailment	Yes	No	Treatment
Eyes (e.g. blurred vision, double vision, loss of vision)			
Ears, Nose, Throat (e.g. sore throat, earache, ringing)			
Heart			
Lung / Respiratory			
Diabetes			
Liver / Hepatitis			
Kidney / Urinary / Bladder			
Skin			
Stomach / Intestinal			
Musculoskeletal (e.g. joint, muscle, back or neck pain)			
Cancer			
Blood Disorder			
Neurological (e.g. numbness, tingling, weakness)			
Mental Health (e.g. depression, anxiety, memory loss)			
Allergic / Immunologic (e.g. rash, swelling, wheezing)			
Other / Medical Problem not Listed			

ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc.) and type of reaction you experience: _____

_____

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Name:_____ / MR#_____

MEDICATION: Has your child ever had a bad reaction to medication? ☐ yes ☐ no If yes, please explain: _____

_____

Does your child take any medications? ☐ yes ☐ no If yes, please list:

Medication: _____ Dose _____ Times taken per day _____

Medication: _____ Dose _____ Times taken per day _____

Medication: _____ Dose _____ Times taken per day _____

BLOOD: Has your child ever had a blood transfusion? ☐ yes ☐ no

SURGERY: Has your child ever had a previous surgery? ☐ yes ☐ no

Surgery/Date: _____ Surgeon _____ Hospital _____ Complications _____

Surgery/Date: _____ Surgeon _____ Hospital _____ Complications _____

Surgery/Date: _____ Surgeon _____ Hospital _____ Complications _____

Describe any surgical complications: _____

_____

Has your child ever had **problems with anesthesia**? ☐ yes ☐ no If yes, please describe: _____

_____

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

_____ ___ / ___ / ___
Patient Signature Date

_____ ___ / ___ / ___
Guardian Signature Date

_____
Guardian/Authorized Representative Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.

Any Changes

□ yes □ no _____ ___ / ___ / ___
Signed Date