Stewart Family Medicine
PEDIATRIC HISTORY SHEET

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your permission.

Today's Date:	Child's Name:	**ALLERGIES**
Parent(s) Name:		
Child's Birthdate:	School Grade:	
Age:	Nickname:	A. Please list medication(s) to which your child is allergic:
BIRTH HISTORY		
Birth parents names:		
Child's Birth Weight: ______lbs ______oz		B. Please list anything else he/she is possibly allergic to:
Were there any problems with the pregnancy, labor, or delivery? Yes or No		
If yes, please explain:		

FAMILY HISTORY

Please be sure to list any family problems below, including: **ANEMIA, SICKLE CELL, BIRTH DEFECTS, ASTHMA, SMOKING, DRUGS, OBESITY, OR CANCER**

LIVING RELATIVES & AGE	**SPECIFY CHRONIC ILLNESS(ES)**
Grandfather (maternal)	
Grandmother (maternal)	
Grandfather (paternal)	
Grandmother (paternal	
Father	
Mother	
Sibling (s)	

DECEASED RELATIVES & AGE AT DEATH	**CAUSE OF DEATH**
Grandfather (maternal)	
Grandmother (maternal)	
Grandfather (paternal)	
Grandmother (paternal	
Father	
Mother	
Sibling (s)	

MEDICAL HISTORY (Please CIRCLE Yes or No)	**If Yes, please explain:**
1. Has your child ever been hospitalized? Yes or No	
2. Has your child ever had surgery? Yes or No	
3. Has your child ever had a repeated illness? Yes or No	
4. Has your child ever had a complicated illness? Yes or No	
5. Has your child ever had a reaction to any medication? Yes or No	
6. Has your child ever been allergic to anything? Yes or No	
7. Is your child on regular medications? Yes or No	
8. Is your child behind on immunizations? Yes or No	
9. Does anyone in the home smoke? Yes or No	

GENERAL MEDICAL REVIEW

Please **CIRCLE** any of the following illnesses that your child has had

Anemia	Blood Transfusions	Bone Disease/Spine Curvature/Repeated or Severe Sprains
Hernia	Bleeding Disorders	Back Trouble
Frequent Headaches	High Blood Pressure	Drug Reaction
Diabetes	Asthma or Hay fever	Ear Disease (More than 3 ear infections)
Painful Urination	Kidney Stones	Allergies
Ulcer	Skin Disease	Heart Disease
Cancer	Pneumonia	Convulsion
Heart Murmur	Other____________________________	Other____________________________

MEDICATION: Is your child on any medications? If yes, please list below

SURGERY: Please **CIRCLE** any operations you have had on any of the following:

Appendix	Kidney	Breast
Tonsils	Tumor	Chest

Other (please explain)

SYSTEM REVIEW: Please **CIRCLE** any of the following symptoms that **your child has or had:**

1. GENERAL HEALTH	**2. ENDOCRINE GLANDS**	**3. SKIN**

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Unexplained Fever	Goiter	Rash
Frequent Infections	Excessive Thirst	Boils
Behavior Problems	Excessive Hunger	Sores
Learning Problems	Underactive Thyroid	Eczema
Loss of Appetite	Overactive Thyroid	Moles
Significant Weight Gain/Loss		Birth Marks
Very "Picky" Eating Habits		Burns
4. LYMPH NODES	**5. EYES**	
Neck Swelling/Pain	Wear Glasses	Wear Contacts
Armpit Swelling	Difficulty Seeing	Double Vision
Groin Swelling	Crossing Eyes	Blind Vision
Prolonged Swollen Glands	Blurred Vision	Eye Disease/Injury
6. EARS	**7. NOSE AND SINUSES**	
Difficulty Hearing	Frequent Nosebleeds	
Pain in Ears	Sinus Congestion/Runny Nose	
Frequent Ear Infections	Hay Fever	
8. LUNGS/CHEST	Previous Chest X-RAY	**9. MOUTH AND THROAT**
Cough	Positive TB Skin Test	Sores in the Mouth
Wheezing	Coughing Up Blood	Hoarseness
Emphysema	Chronic Bronchitis	Problems with Tonsils
Chest Discomfort	Heart Murmur	Dental Problems
Rapid Heart Beat	Palpitation(s)/ Heart Thump	Sore Throat
Irregular Heart Beat	Vein Problems in Legs	Snoring/Deep Breath During Sleep
Shortness of Breath	Get Winded Easily	
10. ABDOMINAL ORGANS		**11. HEART AND BLOOD VESSELS**
Abdominal Pain	Ulcers	Heart Disease
Heartburn/Indigestion	Blood or Mucus in Stools	Heart Murmur
Hemorrhoids	Rectal Pain	Chest Pain
Vomiting	Bloating After Meals	Wake Up Short of Breath
Diarrhea	Frequent Use of Antacids	Sleep on 2 or More Pillows
Hepatitis	Problem Swallowing	Rheumatic Fever
Black, Tarry Stools	Change in Bowel Habits	Swelling in Ankles
Jaundice	Liver Disease	Cramps in Legs
Gallstones	Constipation	
12. KIDNEYS OR BLADDER		**13a. GENITALS (BOYS ONLY)**
Difficult/Painful Urination	Frequent Night Urination	Venereal Disease
Very Frequent Urination	Blood in Urine	Disease or Abnormality of Genital Area
Kidney Disease	Frequent Infections	
Protein in Urine	Kidney Stones	
Can't Hold Urine	Sugar in Urine	
Bed Wetting or Daytime Soiling		
13b. GENITALS (GIRLS ONLY)		**14. MUSCLES, BONES AND JOINTS**
Irregular Periods	Abnormal Bleeding	Deformities
	Age when menstrual period began:__________	
Breast Lumps/Tenderness		Pain in Joints
	Date last period began:__________________	
Venereal Disease		Swelling in Joints
Unusual Vaginal Discharge		Muscle Weakness
Pelvic Pain		Chronic Pain in Back
Nipple Discharge		Gout
15. NERVOUS SYSTEM		
Frequent/Severe Headaches	Severe Anxiety	ANYTHING ELSE YOU WANT US TO KNOW ABOUT YOUR CHILD?
Head Injury	Numbness or Tingling	
Seizures/Fits/Convulsions/Epilepsy	Suicidal Thoughts	
Weakness	Desire Psychiatric Help	
Difficulty Sleeping	Feel Sad or Depressed	

16. IMMUNIZATIONS

Please give the year of last injection for the following:

Tetanus____________________

Tuberculosis Skin Test_________

**If you've never had one or both of the tests, please indicate so here:_________