Unifour FamilyPractice
Your medical home.

Personal Health History Form- Pediatric

Print

Name_____ DOB____/____/_____

Who was your previous Primary Care Provider/Health Clinic? _____

Address / Phone / Fax Number _____

Which pharmacy do you use? _____

Current Medication (Including over-the-counter and vitamins/supplements):

Medication	Dose	Times daily	Medication	Dose	Times daily

Allergies *(Medications, Food, Environmental):*

Allergy: _____ Type of reaction: _____

Allergy: _____ Type of reaction: _____

Allergy: _____ Type of reaction: _____

Allergy: _____ Type of reaction: _____

☐ No Known Medication Allergies ☐ No Known Other Allergies

Past Medical History: *Have you ever been diagnosed with any of the following?*

Cardiovascular
- ☐ Heart Defect_____
- ☐ Heart Murmur_____
- ☐ Other_____

Genitourinary
- ☐ Frequent UTI's_____
- ☐ Incontinence/Bedwetting_____

Dermatologic
- ☐ Acne_____
- ☐ Abnormal/Precancerous Moles_____
- ☐ Eczema
- ☐ Other_____

Respiratory
- ☐ Chronic Cough_____
- ☐ Asthma_____
- ☐ Seasonal Allergies_____
- ☐ Other:_____

Endocrine
- ☐ Diabetes: Type 1/Type 2_____
- ☐ Other_____

ENT
- ☐ Recurrent Ear Infections_____
- ☐ Recurrent Strep_____

Gastrointestinal
- ☐ GERD/Reflux _____
- ☐ Hernia _____
- ☐ Irritable Bowel _____
- ☐ Crohn's/Ulcerative Colitis _____
- ☐ Other _____

Psychological
- ☐ Anxiety/Panic Disorder _____
- ☐ Mood Disorder (Bipolar/Depression) _____
- ☐ ADD/ADHD _____
- ☐ Other _____

Neurological/Musculoskeletal
- ☐ Concussion _____
- ☐ Headaches/Migraines _____
- ☐ Passing out/Syncope _____
- ☐ Other _____

Female Patients
- ☐ Last Menstrual Period _____
- ☐ Have you had an abnormal Pap Smear: Yes or No
- ☐ Heavy or Long Periods _____
- ☐ Using Birth Control _____

Previous Surgeries (please list date) ☐ No Previous Surgeries

_____

_____

Previous Hospitalization (please list date) ☐ No Previous Hospitalizations

_____

_____

Social History

School _____ **Current Grade Level** _____

Extracurricular Activities _____

Name_____ DOB_____/_____/_____

Family History:

Family Member		Medical History (Diabetes, Heart disease, Stroke, Cancer etc.)
Father	☐Living DOB:_____ ☐Deceased (age:___)	
Mother	☐Living DOB:_____ ☐Deceased (age:___)	
Brothers _____ Sisters _____	☐Living DOB:_____ ☐Deceased (age:___)	
Paternal Grandfather	☐Living DOB:_____ ☐Deceased (age:___)	
Paternal Grandmother	☐Living DOB:_____ ☐Deceased (age:___)	
Maternal Grandfather	☐Living DOB:_____ ☐Deceased (age:___)	
Maternal Grandmother	☐Living DOB:_____ ☐Deceased (age:___)	

Any other significant Family Medical History?_____

_____

Review of Systems

Are you currently experiencing any of the below – Circle any positive response

Yes	No	General	Yes	No	Gastrointestinal
☐	☐	Fatigue: Duration_____	☐	☐	Diarrhea
☐	☐	Weight Gain/Loss	☐	☐	Constipation
☐	☐	Loss of Appetite	☐	☐	Abdominal Pain/Nausea
☐	☐	Fever	☐	☐	Rectal Bleeding
		Cardiovascular	☐	☐	Heartburn/Indigestion
☐	☐	Chest Pain			**Endocrine**
☐	☐	Shortness of Breath	☐	☐	Increased Thirst
☐	☐	Swelling of legs	☐	☐	Increased Urination
☐	☐	Palpitations/Fluttering	☐	☐	Heat/Cold Intolerance
		Dermatologic			**EENT**
☐	☐	Skin Rash/Itching	☐	☐	Vision Changes
☐	☐	New or changing Moles	☐	☐	Hearing Changes
☐	☐	Skin Ulcer/Burn/Abscess	☐	☐	Seasonal Allergies
☐	☐	Easy Bruising/Bleeding	☐	☐	Cough/Congestion
		Musculoskeletal/Neuro	☐	☐	Sore Throat
☐	☐	Numbness/Tingling	☐	☐	Nose Bleeds
☐	☐	Injury/Fractures			**Urinary**
☐	☐	Joint Pain/Swelling	☐	☐	Burning/Itching
☐	☐	Back Pain	☐	☐	Blood in Urine
☐	☐	Muscle Weakness	☐	☐	Back Pain
		Psychological			
☐	☐	Anxiety/Panic Attacks			
☐	☐	Depression			
☐	☐	Inattentiveness			