



# LMG Family Practice

## Pediatric Medical History

PLEASE PRINT

THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORD

PLEASE PRINT

**PATIENT'S NAME**

**PARENTAL INFORMATION**

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ RELIGION(OPTIONAL) \_\_\_\_\_  
 AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ FATHER'S OCCUPATION \_\_\_\_\_ MOTHER'S \_\_\_\_\_  
 TODAY'S DATE \_\_\_\_\_ PREVIOUS PHYSICIAN (FOR CHILD) \_\_\_\_\_

MEDICATION OR VITAMINS \_\_\_\_\_  
 ALLERGIES (MEDICATION REACTIONS) \_\_\_\_\_

**PAST HISTORY** (GIVE NAMES AND DATES)

PREVIOUS SURGERY OR FRACTURES \_\_\_\_\_

PREVIOUS HOSPITALIZATIONS \_\_\_\_\_  
 MAJOR ILLNESS OR INJURY \_\_\_\_\_

**IMMUNIZATION DATES**

	1	2	3	4	5
DTP					
DPV					
MMR		INFLUENZA VACCINE		CHICKEN POX (VARICELLA)	
TD				TINE	

CHECK IF ANY RELATIVES HAVE HAD:	IF CHECKED, WHO (RELATION TO PATIENT)
DIABETES _____ <input type="checkbox"/>	_____
HEART TROUBLE _____ <input type="checkbox"/>	_____
HEART ATTACK _____ <input type="checkbox"/>	_____
HIGH BLOOD PRESSURE _____ <input type="checkbox"/>	_____
STROKE _____ <input type="checkbox"/>	_____
CANCER _____ <input type="checkbox"/>	_____
TUBERCULOSIS _____ <input type="checkbox"/>	_____
ULCERS _____ <input type="checkbox"/>	_____
HIGH CHOLESTEROL _____ <input type="checkbox"/>	_____
OBESITY (OVER WEIGHT) _____ <input type="checkbox"/>	_____
SUICIDE _____ <input type="checkbox"/>	_____
EMOTIONAL PROBLEMS _____ <input type="checkbox"/>	_____
THYROID TROUBLE _____ <input type="checkbox"/>	_____
ALCOHOL PROBLEM _____ <input type="checkbox"/>	_____
LEARNING DISABILITY _____ <input type="checkbox"/>	_____
ALLERGIES _____ <input type="checkbox"/>	_____
CONVULSIONS _____ <input type="checkbox"/>	_____
ASTHMA _____ <input type="checkbox"/>	_____
HISTORY OF CHILD ABUSE _____ <input type="checkbox"/>	_____
OTHER _____ <input type="checkbox"/>	_____

**FAMILY HISTORY**

NAMES	YEAR OF BIRTH IF LIVING	AGE AT DEATH	PRESENT MEDICAL CONDITION (S) OR CAUSE OF DEATH
GRANDPARENTS MOTHER'S SIDE _____			
GRANDPARENTS FATHER'S SIDE _____			
FATHER _____			
MOTHER _____			
BROTHERS _____			
SISTERS _____			

**PREVENTION**

DOES ANYONE IN THE HOUSE SMOKE?  
 NO \_\_\_\_\_ YES \_\_\_\_\_ (IF YES, CONTINUE)  
 WHO? \_\_\_\_\_  
 DO THEY SMOKE INDOORS?  
 NO \_\_\_\_\_ YES \_\_\_\_\_

IS THE CHILD'S HOME (APT) EQUIPPED WITH A SMOKE ALARM?  
 NO \_\_\_\_\_ YES \_\_\_\_\_, IN \_\_\_\_\_  
 \_\_\_\_\_ BEDROOM AREA OR HALLWAY  
 \_\_\_\_\_ OUTSIDE IT  
 \_\_\_\_\_ LIVING AREA  
 (CHECK ALL THAT APPLY)

WHEN IN A CAR, IS CAR SEAT OR SEAT BELT USED FOR THE CHILD?  
 NEVER \_\_\_\_\_ MOST OF THE TIME \_\_\_\_\_  
 SOMETIMES \_\_\_\_\_ ALWAYS \_\_\_\_\_

DO PARENTS WEAR SEAT BELTS?  
 NEVER \_\_\_\_\_ MOST OF THE TIME \_\_\_\_\_  
 SOMETIMES \_\_\_\_\_ ALWAYS \_\_\_\_\_

**SCHOOL**

DOES YOUR CHILD ATTEND: (CHECK ALL THAT APPLY)  
 SCHOOL (GRADE K OR ABOVE) \_\_\_\_\_ PRESCHOOL \_\_\_\_\_  
 DAY CARE CENTER \_\_\_\_\_ SPECIAL ED CLASSES \_\_\_\_\_  
 BABY SITTER \_\_\_\_\_

WITH SCHOOL, ARE THERE ANY:  
 SPECIAL NEEDS? NO \_\_\_ YES \_\_\_  
 ACADEMIC PROBLEMS? NO \_\_\_ YES \_\_\_  
 BEHAVIORAL PROBLEMS? NO \_\_\_ YES \_\_\_  
 PLEASE DESCRIBE \_\_\_\_\_

HAS YOUR CHILD EVER HAD DENTAL EXAM? YES \_\_\_\_\_ NO \_\_\_\_\_ WHEN? (OR WHAT AGE) \_\_\_\_\_