Northern **M**ichigan **M**edicine and **P**ediatrics
Pediatric Annual Medical History Form

Name: _________________________ Date of Birth: _______________

Name of adult accompanying child: _______________________________ Relation: _________________

Medication	Dose	Directions

Is your child allergic to any medications? ☐ **YES** ☐ **NO**
If Yes; what medication, what was the reaction? ____
Is either parent of the child allergic to any medication? ☐ **YES** ☐ **NO**
If Yes; ☐ **Mom** ☐ **Dad what medication, what was the reaction?** ___________________________________

Medical History (Please check (X) if your child has had any of the following medical problems)

☐ ADD/ADHD ☐ Abdominal Pain ☐ Acne ☐ Allergic Rhinitis ☐ Allergies
☐ Anemia ☐ Asthma ☐ Bleeding Disorder ☐ Bronchiolitis
☐ Bronchitis ☐ Chicken Pox ☐ Concussion/Closed Head Injury ☐ Constipation
☐ Diabetes ☐ Eczema ☐ Fracture ☐ Headaches ☐ Migraines
☐ Hearing Problems ☐ Heart Murmur ☐ Heart Disease Congenital ☐ Kidney Infection
☐ Menstrual Problems ☐ Pneumonia ☐ Recurrent Ear Infections ☐ Reflux Disease
☐ Urinary Tract Infections ☐ Vesicoureteral Reflux
☐ Turner's Syndrome ☐ Down Syndrome

Other (specify):____

Female History:
Age at 1st period: ________ 1st day of most recent period: _____________ Has not yet had menses: ___

Surgical History

Type of Surgery	Date:	Surgeon (If known)

Birth History
Please indicate any medical problems during pregnancy: _______________________________________
Delivery: ___ elective C-section __ emergency C-section __normal vaginal delivery
Gestational Age: ☐ Full Term ☐ Premature ________weeks ☐ Overdue ________weeks
Birth Weight_____________ Birth length: _______________ ☐ Breast fed ☐ Formula fed

OVER

Family History

Relative	Heart Disease	High Blood Pressure	Diabetes	Mental Illness	Breast Cancer	Ovarian Cancer	Colon Cancer	Other Illness or Condition	Age if living	Age of Death
Father	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____
Mother	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____
Brother	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____
Sister	☐	☐	☐	☐	☐	☐	☐	☐ __________	_____	_____

Social History

Who lives at home: ____

Do any household members smoke? ☐YES ☐ NO Smoke outside only? ☐YES ☐NO

Are the child's parents: married, divorced, separated, living together, never together? _______________

Does your child attend a childcare provider? ☐YES ☐NO # Days per week: _____

School Name _____________________________ Grade ____________

Car restraints/Car seat ☐Rear facing ☐Front facing ☐Booster ☐Seat belt ☐None

Carbon monoxide detector? ☐YES ☐ NO Smoke detector? ☐YES ☐ NO

Pets or animals at home? ☐YES ☐NO If yes, what type? ___________________

Exercise / Sports? ☐YES ☐NO Type? __________________ Hours per day ______

Sleeps through the night? ☐YES ☐NO # of hours of sleep______ Sleeps with parents? ☐YES ☐NO

Takes naps? ☐YES ☐NO

Good appetite? ☐YES ☐NO Other: _______________