

KU Wichita USD 261 Haysville / School-Based Health Care

PEDIATRIC PATIENT MEDICAL HISTORY FORM

(please complete both sides – attach additional form if needed)

Date	Child's Name		DOB
Primary Care Physician (PCP)		PCP Phone Number	Date of Last Well Child Exam
Mother's Full Name		Father's Full Name	
Custodial provider (If different from above)		Relationship to Patient	
Does the child have an eye doctor? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please provide name and date of last exam)		Does the child have a dentist? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please provide name and date of last appointment)	
Preferred Pharmacy Name, Address, phone number			
With whom does the child live (list all household members and their relationship to child):			
Does anyone smoke in or outside the home? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Is this child currently or has he/she ever been in foster care? <input type="checkbox"/> No <input type="checkbox"/> Yes, currently (specify age child entered foster care _____) <input type="checkbox"/> Yes, in the past (specify ages in foster care _____)			

Birth and Development History	
Birth weight _____ Pregnancy # _____ Mom's age at delivery _____ Type of birth: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean (reason _____) <input type="checkbox"/> Term <input type="checkbox"/> Premature (how many weeks early _____) Did mom have any illnesses/problems during pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain _____) Before mom knew she was pregnant or anytime during her pregnancy, did she use: <input type="checkbox"/> Cigarettes (how many per day? _____) <input type="checkbox"/> Alcohol (drinks per week? _____) <input type="checkbox"/> Any other substance/drug, prescribed or not, to get "high" (type and how often? _____)	Did your child have any problems during or after birth? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain _____) Did your child have any developmental delays? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain _____) Does your child receive any services at school for a developmental, behavioral, or medical diagnosis such as a 504 or Individualized Education Plan (IEP)? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain _____) Does your child see any medical specialists? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain _____)

Medical History			
List current medications your child is taking (attach additional page if necessary):			
Medication Name	Dosage	Time of Day Taken	Prescribers Name
List any allergies your child has to foods or medications: _____ _____			
Has your child received all the recommended vaccinations recommended for their age? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, why? _____)			

Medical History (Continued from previous page)
List any surgeries your child has had and the year they had the surgery: _____ _____
List any medical illnesses your child has (asthma, diabetes, seizures, migraines, etc.): _____ _____
List any mental health diagnoses your child has and who is providing treatment (therapists, physicians, APRNs, counselors, etc.): _____ _____
List any surgeries or overnight hospitalizations your child has had: _____ _____

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)			
Have Any Family Members Had the Following:			
Alcohol/Drug Abuse	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Allergies	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Birth Defects	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Blood Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Bone Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Endocrine Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Ear/Nose/Throat Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Eye Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Gastrointestinal Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
High Cholesterol	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Immune Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Joint Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Liver Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Lung Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Migraine Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Metabolic Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Obesity	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Seizure Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Skin Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Stroke History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Thyroid Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Mental Health History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Other Medical History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:
Other Medical History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Details:

Please list any other pertinent information to your child's medical history for the medical provider: _____ _____ _____ _____
--