First Steps™
PEDIATRICS & ADOLESCENT MEDICINE

Complete Patient Medical History

Patient Name: _____

Date of Birth: _____ Sex: _____ Age: _____

Medication Allergies: _____

Please list all individuals living in household and their relationship to the patient: _____

_____

_____

Please list all medications patient is currently taking including Vitamins, fluoride, herbal supplements and over the counter medications: _____

_____

_____

Current Diet: _____ If infant;Breast or Formula: _____ Brand: _____

Appetite: _____ Feeding problems: _____

List all allergies to foods or environment: _____

_____

Please list previous illnesses, surgeries and past hospitalizations with dates:

_____

_____

_____

If menstrual; date of first period: _____ Date of last period: _____

	Dates of past immunizations			
DTaP				
HIB				
Polio				
MMR				
Hepatitis B				
Varicella				
Prevnar				
Other				

Which parents work outside the home? _____

What kind of sitter arrangements does the child have? _____

If divorced or unmarried is the other parent involved with the child? _____

Has child ever eaten anything unusual such as paint chips, dirt, plants, etc.? _____

If yes, please explain:_____

_____

Was child adopted? _____ If yes, at what age? _____

Mother's health during pregnancy of this child: Good_____ Complications _____

If complications, please describe:_____

_____

Which pregnancy number was this for Mom? _____ Normal delivery or c- section? _____

What was child's birth weight?_____ Birth length?_____

Where was child born? Name of Hospital: _____

Was the child diagnosed with any problems at birth? _____

Was child hospitalized after mother's discharge? _____

Of the child's 4 grandparents, how many are living and well? _____

Do any blood relatives of child have any of the following conditions:

Disease	No	Yes	Whom- specify relationship to child plus Maternal or Paternal
Diabetes			
Kidney Disease			
Blood Disorders			
Arthritis			
Asthma			
Eczema			
Thyroid Disorder			
High Blood Pressure			
Heart Disease			
Cancer (specify)			
Tuberculosis			
Seizure Disorder			
Mental Retardation			
Seasonal Allergies			
Unusual Defects or Syndromes			
Other conditions not listed			

Compared to other children was this child's development: Slower, Faster, or Average? (please circle)

If attending school, type of grades achieved: _____

Are there any problems with child getting along at home or with playmates? _____

If yes, please explain_____

_____

Has child even been under professional mental health care of counseling? _____ If yes, by whom?

_____

Please list all pets in the home or that child has contact with: _____

_____

Water source: City _____ Well _____ Bottled _____

Is home air-conditioned? Yes___ No ___

Heat source: Gas _____ Electric _____ Other _____

Smokers present in home? Yes _____ No _____ Whom? _____

Has child ever had any of the following conditions? Please check and explain in lines below

Allergies		Nosebleeds		Bed wetting		Bleeding tendency	
Asthma		Measles		Eczema		Rheumatic Fever	
Anemia		Pneumonia		Frequent Diarrhea		Fractures (specify)	
Chicken Pox		Slow Growth		Frequent Illness		Mononucleosis	
Backaches		Ear Infections		Unusual Weight Loss		Attention Deficit	
Sore Throats		Vision Problems		Unexplained Fevers		Worms	
Headaches		Hearing Problems		Urine/ Kidney Problems		Eating Disorder	
Seizures		Speech Problems		Menstrual difficulties		Depression	
Sore or Swollen Joints		Protein, Blood or Sugar in Urine		Problems with walking or posture		Loss of Consciousness or Been knocked out	

_____

_____

_____

_____

_____

_____

Parent, Patient or Guardian's Signature: Date:

X_____ _____

Thank you for your cooperation