Western Michigan University — Homer Stryker M.D. — School of Medicine

Pediatric Health History

(Please complete in ink)

Today's Date: _____ **MRN:** _____ **Date of Birth:** _____

Last Name:	First :	Middle:
Sex:	Race:	
Name of parent(s):		
Legal guardian (if other than parent):		
What is the primary language of the household?		
Patient's school:		
If your child has significant medical problems would you like to talk to a physician about guidelines for life-threatening situations? Yes No N/A		

MEDICAL HISTORY:

List the **child's medical problems**:

_____

_____

_____

_____

SURGICAL HISTORY:

List the **child's surgical procedures:**

_____

_____

_____

Name of previous physician(s): _____

Name of primary care physician: _____

Name of specialty physician(s): _____

PAST MEDICAL HISTORY:

Full-term birth: Yes No Birth Weight:	If premature, by how many weeks:
Mother's complications during pregnancy? (please specify):	
Mother's medications during pregnancy:	
Any problems during delivery?	
Mother's previous number of pregnancies:	Number of live births:
Any known developmental delays? Slow to walk? Roll over? Crawl? Failure to thrive? Other (please specify):	
Do you have documentation of your child's immunizations? Yes No If yes, did you bring a copy with you today? Yes No If no, did you request the records to be sent to us? Yes No	

Original Effective Date: 07/25/03
Revised Date: 10/01/05
06/16/10
07/12/10

Name: _____ **MRN:** _____ **Date of Birth:** _____

MEDICATIONS:

List all medications the child is taking; including vitamins, herbal preparations and over the counter medications.

Name of Medication:	Dosage of Medication:	How often the medication is taken/what time of day the medication is taken:

Allergies and reactions to drug, food or environment (please list):

FAMILY HISTORY:

Please tell us about the **health** of the **child's parents, brother(s) and/or sister(s) and grandparent(s):**

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Grandparent(s): _____

Other family history of note: _____

PSYCHOSOCIAL:

Has the family had recent changes which may cause stress? Yes No
Has there ever been any domestic violence or incidents of physical, verbal or sexual abuse in your household? Yes No
Are any community agencies assisting the patient? Yes No Please state contact person:
Does the child have any special needs? Yes No
Do you have any cultural, religious or spiritual beliefs that affect the decisions you make about the child's medical care? Yes No If yes, please explain:
Is the child currently having thoughts of harming himself/herself or others? Yes No

FUNCTIONAL:

Have there been any recent changes in the child's mobility, use and function of arms or legs? Yes No Any difficulty performing daily activities or problems speaking or swallowing? Yes No Have there been any changes in the child's eating habits? Yes No If yes, please explain:
Is the child on a special diet? Yes No If yes, please explain: Has the child had any recent changes in his/her weight? Yes No If yes, please explain:
Name of person completing form/relationship to patient (please print): **Signature:**

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