Myrtle Ridge Family Medicine

Pediatric Health History

Patient's Name: _____ DOB_____ M or F

Parent's Name:_____ Other family members come to MRFM?_____

Why did you bring your child to the doctor today? _____

What health problems has your child had?			Please explain:	Date began
Problems at birth	Y	N		
Allergies	Y	N		
Eyes, Ear/Nose/Throat	Y	N		
Heart	Y	N		
Lung	Y	N		
Gastrointestinal	Y	N		
Muscle/Bone/Joint	Y	N		
Skin	Y	N		
Blood	Y	N		
Emotional/ADHD	Y	N		
Nutrition	Y	N		
Other disease/conditions?	Y	N		

Medications (and dose):

Over-the-counter or herbal medication

Allergies to medications (& reaction)

1_____

2_____

3

Has your child had any surgeries? Date

1_____

2_____

Hospital admissions Date

1_____

2_____

Does your child see any specialists? Date

1_____

2_____

Your Child's Social History

Does your child go to day care?_____

What grade in school is your child in?_____

School Name_____

Any problems in school?_____

Does your child have special interests (reading, sports, etc)?

_____

DON'T FORGET TO BRING IN YOUR CHILD's IMMUNIZATION RECORD

Family History		Living ?		Health problems, or cause of death
Father	Age_____	Y	N	
Mother	Age_____	Y	N	
Brother	Age_____	Y	N	
and	Age_____	Y	N	
Sisters	Age_____	Y	N	
	Age_____	Y	N	

Parents Social History

Are parents single/married/divorced?_____When?_____

Mom's occupation_____

Dad's occupation_____

Who lives in the home?_____

Does anyone in the home use tobacco? _____Alcohol?_____

Do any household members have serious health problems?_____

_____

Other family nearby to help with child care?_____

How long have you lived in Tampa?_____

Any other improtant information for the doctor?_____

_____

Signature_____ **Date**_____