INFINITY PRIMARY CARE

INFINITY PRIMARY CARE
PEDIATRIC HISTORY FORM
5 yrs. and older - PLEASE PRINT
(with Blue or Black Ink)

Today's Date:____________
Physician:_________________

Name: (last) _________________________________ (first) ___________________________ Date of Birth: _________________

Language spoken at home:________________________

MEDICATIONS:
Please list all medications (including over-the-counter, vitamins, supplements, and/or inhalers)

NAME **STRENGTH** **FREQUENCY**

1.____

2. ____

3.____

4.____

5.____

ALLERGIES:
Is patient allergic to any drugs or medications?
☐ No ☐ Yes If yes, what?

Does the patient have any food allergies?
☐ No ☐ Yes If yes, what?

Does the patient have any other allergies?
☐ No ☐ Yes If yes, what?

REVIEW OF SYSTEMS: Please check any symptoms you have had RECENTLY

Constitutional
O Chills
O Decreased activity
O Decreased appetite
O Fever
O Fussiness
O Weight gain
O Weight loss

HEENT
O Difficulty swallowing
O Ear drainage
O Esotrophia (cross eye)
O Eye discharge
O Eye redness
O Headache
O Hearing loss
O Nasal congestion
O Ear pain
O Sore throat
O Runny nose
O Sneezing
O Tearing
O Visual loss

Respiratory
O Breathing difficulty
O Use of accessory muscles
O Cough
O Sputum
O Wheezing

Cardiovascular
O Chest pain
O Palpitations
O Fainting

Vascular
O Cool extremity
O Blue coloration

Gastrointestinal
O Abdominal pain
O Constipation
O Diarrhea
O Nausea
O Reflux
O Vomiting

Genitourinary
O Decreased urine output
O Painful urination
O Urinary incontinence
O Flank (side) pain
O Foul urine odor
O Blood in urine

Reproduction
(Female Only)
O Painful period
O Heavy flow
O Vaginal discharge
O Vaginal Itching
O Start Period age:____
Last Period________
O Irregular menses
O Oral contraception

(Male Only)
O Circumcised
O Penile discharge
O Scrotum testicular mass
O Scrotum testicular pain

Metabolic/Endocrine
O Excessive thirst
O Excessive urination

Neurological
O Inappropriate interaction
O Behavioral changes
O Inconsolable
O Difficulty concentrating
O Distorted body image
O Self conscious

Skin
O Acne
O Itching
O Rash
O Skin lesion

Musculoskeletal
O Bone pain
O Joint pain
O Joint swelling
O Muscle weakness
O Muscle pain

Hematologic/Lymphatic
O Easy bleeding
O Easy bruising
O Enlarged lymph nodes

Immunologic
O Seasonal allergies
O Environmental allergies
O Food allergies
O Urticaria (Hives)

Name: _________________________________ **DOB:**___________________

MEDICAL CONDITIONS: Please mark any illness or disease you have had in the past or currently may have:

O Acne
O ADD
O ADHD
O Allergic rhinitis
O Anemia
O Asthma
O Birth Trauma
O Bleeding disorder
O Bronchiolitis
O Bronchitis

O Chicken pox
O Concussion
O Congenital heart disease
O Diabetes
O Eczema
O Fracture(s)
Specify_________________
O GERD
O Head Injury
O Headache, migraine

O Headaches
O Hearing problems
O Heart murmur
O Ear infections, recurrent
O Pneumonia
O Prematurity
O Kidney infection
O Seizure disorder
O Seizures, febrile
O Urinary tract infection

O Vesicoureteral reflux
O Other
Specify_________________
O Genetic disease
O Meningitis
O Developmental issues

SURGICAL/HOSPITALIZATION HISTORY: (if marking an item below please include the year it occurred)

O Adenoidectomy ______
O Appendectomy ______
O Blood transfusion ______
O Dental surgery ______

O Hernia Repair, inguinal _____
O Hernia Repair, umbilical _____
O Lymph node biopsy/excision _____
O Tonsillectomy _____

Other______________
O Tympanostomy (Ear Tubes)
Right Left Both

What diagnostic, screening studies or immunizations has the patient had previously? Please list most recent date.

Complete Physical ___________ Last Cholesterol ___________

Last Eye Exam ___________ Last Hearing Test ___________

Has child had all immunizations for his/her age?______________ If not, reason ____________________

Which ones are missing?___________________________ Can we give them today?_________________

Name: _______________________________ DOB:__________________

FAMILY HISTORY: **Check below to report problems the patient's family members have had. Please state age when they had the problem if you know it and if this was a cause of death.**

☐ **Adopted (unknown family history)**

Condition	Whom	Onset Age	Cause of Death?
ADD/ADHD			
Allergies			
Asthma			
Birth defects			
Cancer (list type)			
Heart disease			
Deafness			
Depression			
Developmental delay			
Developmental dislocation of hip			
Diabetes			
Eczema			
Elevated lipids			
Genetic disease			
Hemoglobinopathy (blood disorder)			
Hypertension			

Condition	Whom	Onset Age	Cause of Death?
Learning disability			
Mental retardation			
Migraines			
Obesity			
Kidney disease			
Scoliosis			
Seizure disorder			
Sudden infant death syndrome (SIDS)			
Thyroid disease			
Alcoholism			
Substance Abuse			
Mental Illness			
Celiac Disease			
Stroke			
Other			

RELATIONSHIPS:

Child Care Provider: ____________________ Number of days/week____________

Who lives at the primary residence?_____________________ Who lives at the secondary residence?______________________

Marital status of parents:__________________

Siblings: How many?____________________ Birth order:____________

Smokers at home? ☐ No ☐ Yes If yes, smoke outside only? ☐ No ☐ Yes

HOME ENVIRONMENT:

Is there lead in the home? ☐ No ☐ Yes ☐ Removed ☐ Unknown

Uses bike/skating helmet: ☐ No ☐ Yes

Car restraints: ☐ Car seat: face rear ☐ Booster ☐ None
☐ Car seat: face front ☐ Seat belt

Carbon Monoxide Detectors in home: ☐ No ☐ Yes

Smoke Detectors in home: ☐ No ☐ Yes

Radon in home: ☐ No ☐ Yes ☐ Untested ☐ Treated

Pets/animals at home: ☐ No ☐ Yes If yes, what kind?____

Firearms at home: ☐ No ☐ Yes If yes, locked storage: ☐ No ☐ Yes
Ammo stored separately: ☐ No ☐ Yes

Name: ________________________________ DOB:___________________

EDUCATION:

Grade in school:_________

Grades earned: __________________________

Performing: ☐ Below grade level ☐At grade level ☐ Above grade level

Learning disability: ☐ No ☐ Yes

Special needs: ☐ No ☐ Yes

Gifted program: ☐ No ☐ Yes

SLEEP:

Sleeps with parents: ☐ No ☐ Yes

Sleeps through the night: ☐ No ☐ Yes

Nightmare/sleep problems: ☐ No ☐ Yes

ACTIVITY:

Exercise/sports/activity:______ hours/day Type of exercise/sport?______________ Type of activity?____________________

TV/computer games:______ hours/day Has TV in bedroom? ☐ No ☐ Yes

Internet:______ hours/day Has computer in bedroom? ☐ No ☐ Yes

NUTRITION: (over 5)

Type of Diet: _______________

Concerns: ☐ No ☐ Yes _________________________

Caffeine: ☐ No ☐ Yes

Bladder concerns: ☐ No ☐ Yes

Bowel concerns: ☐ No ☐ Yes

Last Dental Visit: _______________

DEVELOPMENTAL HISTORY:

Did your child achieve developmental milestones in an age appropriate matter?_______________________________________

Please list all specialty Physicians that you have seen in the last year:

Provider Name: ____________________________________

Specialty: ____

Phone Number: ____________________________________

Reason/Diagnosis: __________________________________

Provider Name: ____________________________________

Specialty: ____

Phone Number: ____________________________________

Reason/Diagnosis: __________________________________

Please list the patient's mail order and/or primary pharmacy:

Pharmacy:____

Address:____

Phone No.:____

Pharmacy:____

Address:____

Phone No.:____

The above information is correct to the best of my knowledge.

____ ________________________

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date