MERCER ISLAND FAMILY MEDICINE, PLLC

New Pediatric Patient History

Please bring in your child's immunization records with this questionnaire.

Patient Name: ____ ____________________
Last, First Middle

Address: ____

City: __________________ Zip: ____________ DOB: ____________ SSN: ____________

Child's Phone: _______________ Parents Name/Phone: ______________________________

Past Medical and Family History (Please check all that apply)

	Patient	Mother	Father	Siblings	Grandparents	Aunts/Uncles
Allergies						
Anemia						
Asthma						
Cancer (type?)						
COPD(Emphysema)						
Depression/Anxiety						
Diabetes						
Heart Attack						
Heart Valve Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Liver Disease						
STD						
Stroke						
Thyroid Disease						

Chronic / Past Medical problems: (Include childhood diseases such as chicken pox)

____

____

Birth History- Please complete for children 18 months and younger

Length of pregnancy: _________________ Birth Weight ____________________

Problems with pregnancy, labor, or delivery: ________________________

Any problems at birth: ___________________________________

List Current Medications: (Please include over-the-counter medications and vitamins)

Name ____________ dose ______________ how often you take ______________

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____

____

____

Any known drug allergies:

____

List Past Surgeries: Include dates if known

____

____

List previous hospitalizations: (Other than surgeries)

____

____

Social history:

Who lives at home? (Names and ages of parents/step-parents, siblings)

____

____

Does your child attend daycare in a home or daycare setting?______________________

Name of school and grade level ______________________

What type of sports/activities/hobbies?______________________

Any smokers in the home? ____________ Any pets in the home? ______________

For children 12 years of age and older, please complete the following:

Are you concerned or know of	Yes	No
School Problems		
Social Problems		
Alcohol use		
Drug Use		
Tobacco Use		
Sexual activity		
Prior STD's		
Prior Pregnancies		

Please list other important information (specific problem, drugs used, etc.)