GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

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Pediatric Medical History (13 years and up)

Child's name:_____ Birthdate:_____ Today's Date:_____

Medical History

Has your child ever had a urinary tract infection? ❑ Yes ❑ No (If Yes, what age? _____)
Has your child ever been diagnosed with asthma or wheezing? ❑ Yes ❑ No (If Yes, what age? _____)
Has your child ever had any medical problems? ❑ Yes ❑ No Specify: _____
_____
Has your child ever had any fractures, concussions, or other serious injury? ❑ Yes ❑ No Specify (include age):
_____
Does your child have any allergies? ❑ Yes ❑ No (If Yes, specify): _____
Does your child see any specialists? ❑ Yes ❑ No (If Yes, who?): _____
Has your child ever received Occupational, Physical or Speech therapies? ❑ Yes ❑ No Explain:_____
_____
Surgeries or hospitalizations (where the patient was admitted to the hospital):
Age:_____ Reason: _____ Age:_____ Reason: _____

Family History

Does anyone in your family listed below have any chronic diseases/illnesses (Like diabetes, heart attacks, strokes, depression, asthma, cancer, thyroid) or any other diseases we should know about? Check alive or deceased. If no health issues, check healthy.

❑ Foster Care ❑ Adopted
Father: ❑ Alive ❑ Deceased ❑ Healthy ❑ Other Explain: _____
Mother: ❑ Alive ❑ Deceased ❑ Healthy ❑ Other Explain: _____
Siblings: ❑ Alive ❑ Deceased ❑ Healthy ❑ Other Explain: _____
Father's Father: ❑ Alive ❑ Deceased ❑ Healthy ❑ Other Explain: _____
Father's Mother: ❑ Alive ❑ Deceased ❑ Healthy ❑ Other Explain: _____
Mother's Father: ❑ Alive ❑ Deceased ❑ Healthy ❑ Other Explain: _____
Mother's Mother: ❑ Alive ❑ Deceased ❑ Healthy ❑ Other Explain: _____

Social History

Diet: ❑ Regular ❑ Vegetarian ❑ Vegan ❑ Gluten Free ❑ Diabetic
Exercise: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy
Sporting Activities: _____ Bully/Bullying: ❑ Yes ❑ No
Year in school: _____ Grades in school: _____
Parents marital status: ❑ Married ❑ Unmarried ❑ Separated ❑ Divorced ❑ Widowed
Home situation: ❑ Both Parents ❑ Mother ❑ Father ❑ Relative ❑ Adopted ❑ Foster
Smoke/CO Detectors in home? ❑ Yes ❑ No Guns in home? ❑ Yes ❑ No
Seat belt or car seat used? ❑ Yes ❑ No Bike helmets used? ❑ Yes ❑ No Animal Exposure? ❑ Yes ❑ No
Caffeine intake? ❑ Yes ❑ No How many drinks per day? _____
Do you smoke? ❑ Yes ❑ No How much? _____ Chewing Tobacco? ❑ Yes ❑ No How much? _____
Do you use drugs? ❑ Yes ❑ No How much? _____ Smoke exposure? ❑ Yes ❑ No — ❑ Outside ❑ Inside
Do you use marijuana products? ❑ Yes ❑ No Sexually active? ❑ Yes ❑ No