Mercy
MEDICAL SERVICES
A partner with Mercy Medical Center-Sioux City

PEDIATRIC PATIENT HISTORY (0-18 years)

Please complete to the best of your ability to assist our staff in providing the best possible care for you and/or your family members.

LAST NAME _____ **FIRST NAME** _____ **MI** _____

DATE OF BIRTH _____ **PRIMARY LANGUAGE** _____ **MALE/FEMALE**_____

CHILD'S MEDICAL HISTORY (indicate any significant medical problems along with the date of onset)

Y or N (date of onset)	Medical Problem	Y or N (date of onset)	Medical Problem
	Allergies/Hay Fever		Seizures
	Blood Transfusion		Recurrent Ear Infections
	Premature Birth		MRSA/VRE
	R.S.V.		HIV/AIDS
	Lung Problems		Eczema/Rash
	Hepatitis/Liver problems		Dental Concerns
	Heart Defect/Disease		Sexually Transmitted Disease
	Other:		Other:

MEDICATIONS (if you need more space for medications please ask for another form)

Name of Medication	Dosage	How many times per day	Date Started	Prescribed By

ALLERGIES (circle and explain type of reaction below): Medication Household Products, Animals, Environment

_____

_____

_____

BIRTH HISTORY **ADOPTION** ☐ **Y or N** ☐

Child's Birth Weight		Length of Pregnancy	
Complications with Pregnancy or Birth	☐ Y or N ☐		

PAST SURGICAL AND HOSPITALIZATION HISTORY (any surgeries or hospitalizations along with dates)

Date	Surgery/Hospital Stay	Date	Surgery/Hospital Stay

FAMILY MEDICAL HISTORY-Indicate family member. For extended family, note whether on mother's side (M) or father's side (F).

Medical Problem	Relative (M or F)	Age at onset or death	Medical Problem	Relative (M or F)	Age at onset or death	Medical Problem	Relative (M or F)	Age at onset or death
Alcohol/Drug			Diabetes			Mental illness		
Allergies			Stomach/ intestine			Migraine headaches		
Alzheimer/ Dementia			Bladder/Kidney			Lung problem		
Anesthesia problems			Heart			Stroke		
Arthritis			High Blood Pressure			Thyroid		
Asthma			Cholesterol			Cancer		
Blood disease			Other			Other		

NOTES _____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Tobacco use

- ☐ None in household
- ☐ Quit: packs/day_____ years smoked:_____ quit date:_____ type of tobacco:_____
- ☐ Current smoker: packs/day_____; start date:_____ type of tobacco:_____
- ☐ Second-hand smoke (who in home smokes) _____

Alcohol use (each drink contains 0.5 oz alcohol): (answer for children over 12 years of age)

- ☐ No
- ☐ Yes: Drink(s) per week:_____ Type of alcohol _____

Substance Abuse

- ☐ Yes Type _____ Amount_____ How often_____
- ☐ No

Nutrition and Activity

- ☐ Caffeine (coffee, tea, soda): ☐yes /☐no, if yes, how much per day:_____
- ☐ Diet: ☐good /☐fair /☐bad /☐vegetarian /☐vegan
- ☐ Exercise: types:_____ min per day: _____; times per week:_____

Social and Special needs

- ☐ Do you feel safe at home: ☐yes ☐no
- ☐ Do you have communication needs that affect your medical care: ☐yes /☐no ; if yes explain:_____

Health Care Maintenance (please enter dates: also write N for "normal" or AN for "abnormal"):

Last Physical_____ Last Dental Exam_____ Last eye exam (Dr) _____

Immunizations Up-To-Date _____

Form completed by _____ **Date** _____

REV. 11/28/11