Parsi Pediatrics
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MEDICAL HISTORY FORM

Today's Date _____

Patient Name _____ **Date of Birth** _____
First Middle Last Suffix

Patient Allergies

☐ No Known Allergies ☐ Yes (please indicate below)

Allergen	Symptom	Onset Date

Other: _____

Patient Medications

☐ No Medication History ☐ Yes (please indicate below)

Name of Medication	Dosage	Start Date	End Date (if applicable)

Other: _____

Family History

Is there any history / difficulty of the following with your child or in child's family?

Please indicate **which family member** (e.g. mom, dad, grandma, grandpa, aunt, uncle, etc.) & circle "Mom" or "Dad" to indicate if on mom side of family (Mom) or dad side of family (Dad)

Anemia ☐ Patient ☐ Family _____ (Mom / Dad)	Anxiety ☐ Patient ☐ Family _____ (Mom / Dad)	Arthritis ☐ Patient ☐ Family _____ (Mom / Dad)	Asthma ☐ Patient ☐ Family _____ (Mom / Dad)
Back Problems ☐ Patient ☐ Family _____ (Mom / Dad)	Breast Cancer ☐ Patient ☐ Family _____ (Mom / Dad)	Coronary Artery Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Congestive Heart Failure ☐ Patient ☐ Family _____ (Mom / Dad)
Chronic Obstructive Pulmonary Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Cancer ☐ Patient ☐ Family _____ (Mom / Dad)	High Cholesterol ☐ Patient ☐ Family _____ (Mom / Dad)	Depression ☐ Patient ☐ Family _____ (Mom / Dad)
Diabetes ☐ Patient ☐ Family _____ (Mom / Dad)	Epilepsy ☐ Patient ☐ Family _____ (Mom / Dad)	Gastro-esophageal Reflux Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Glaucoma ☐ Patient ☐ Family _____ (Mom / Dad)
HIV / AIDS ☐ Patient ☐ Family _____ (Mom / Dad)	Headache ☐ Patient ☐ Family _____ (Mom / Dad)	Hepatitis ☐ Patient ☐ Family _____ (Mom / Dad)	Hypertension ☐ Patient ☐ Family _____ (Mom / Dad)

Please Initial _____

Patient Name _____ **Date of Birth** _____
First *Middle* *Last* *Suffix*

Family History (continued)

Myocardial Infarction/ Heart Attack ☐ Patient ☐ Family _____ (Mom / Dad)	Migraine ☐ Patient ☐ Family _____ (Mom / Dad)	Pneumonia ☐ Patient ☐ Family _____ (Mom / Dad)	Renal Stone ☐ Patient ☐ Family _____ (Mom / Dad)
Stroke ☐ Patient ☐ Family _____ (Mom / Dad)	Tuberculosis ☐ Patient ☐ Family _____ (Mom / Dad)	Thyroid Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Ulcer ☐ Patient ☐ Family _____ (Mom / Dad)
ADHD ☐ Patient ☐ Family _____ (Mom / Dad)	Allergies ☐ Patient ☐ Family _____ (Mom / Dad)	Bed Wetting ☐ Patient ☐ Family _____ (Mom / Dad)	Birth Defects ☐ Patient ☐ Family _____ (Mom / Dad)
Bladder Problems ☐ Patient ☐ Family _____ (Mom / Dad)	Excessive Bleeding ☐ Patient ☐ Family _____ (Mom / Dad)	Cerebral Palsy ☐ Patient ☐ Family _____ (Mom / Dad)	Chicken Pox ☐ Patient ☐ Family _____ (Mom / Dad)
Constipation ☐ Patient ☐ Family _____ (Mom / Dad)	Convulsions ☐ Patient ☐ Family _____ (Mom / Dad)	Drug/ Alcohol Abuse ☐ Patient ☐ Family _____ (Mom / Dad)	Recurring Ear Infections ☐ Patient ☐ Family _____ (Mom / Dad)
Eczema ☐ Patient ☐ Family _____ (Mom / Dad)	Fainting ☐ Patient ☐ Family _____ (Mom / Dad)	Gall Bladder Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Hepatitis ☐ Patient ☐ Family _____ (Mom / Dad)
Kidney Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Lead Poisoning ☐ Patient ☐ Family _____ (Mom / Dad)	Liver Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Mental Disorder ☐ Patient ☐ Family _____ (Mom / Dad)
Mononucleosis ☐ Patient ☐ Family _____ (Mom / Dad)	Measles ☐ Patient ☐ Family _____ (Mom / Dad)	Mumps ☐ Patient ☐ Family _____ (Mom / Dad)	Psychological Problems ☐ Patient ☐ Family _____ (Mom / Dad)
Rheumatic Fever ☐ Patient ☐ Family _____ (Mom / Dad)	Seizures from Fever ☐ Patient ☐ Family _____ (Mom / Dad)	Sinus Problems ☐ Patient ☐ Family _____ (Mom / Dad)	Speech Problems ☐ Patient ☐ Family _____ (Mom / Dad)
Urinary Disease ☐ Patient ☐ Family _____ (Mom / Dad)	Vision Problems ☐ Patient ☐ Family _____ (Mom / Dad)		

Other: _____

_____

_____

Patient Immunization History

☐ No Vaccines Administered ☐ Yes Vaccines Administered (please have vaccine record available)

Has patient previously had **chicken pox (varicella)** disease? ☐ No ☐ Yes If so, please indicate date: _____

Has patient previously had **tuberculosis (TB)** disease? ☐ No ☐ Yes If so, please indicate date: _____

Has patient previously had **tuberculosis (TB)** skin test? ☐ No ☐ Yes If so, please indicate date: _____
Result: ☐ Negative ☐ Positive

Patient Birth History

Place of Birth _____ City _____ Country _____
Hospital Name

How many weeks was mom pregnant when baby was born? _____ weeks Birth weight _____ lbs _____ oz

Mom's age when patient was born? _____ What pregnancy # was patient for mom? _____ What # of living children mom had when patient born? _____ What # abortions mom had when patient was born? _____

Please Initial _____

Patient Name _____ **Date of Birth** _____
First *Middle* *Last* *Suffix*

Patient Birth History (continued)

Type of Delivery (*check one*) ☐ Vaginal ☐ Cesarean

Reason for Cesarean Section (*if applicable*) _____

Was baby a breech delivery? ☐ Yes ☐ No

If so, did baby receive a hip ultrasound, and when? ☐ Yes ☐ No

Date of ultrasound _____

If patient is currently less than 28 days old, is mom taking any medication? ☐ No ☐ Yes If so, please indicate below:

_____

_____

_____

Patient Menstrual History (only if patient is a female)

Has Patient started her menses? ☐ No ☐ Yes If so, please indicate the age of onset? _____

Does patient have an Ob/Gyn ☐ No ☐ Yes

Patient Social History

Patient lives with: ☐ Both Parents ☐ Mom ☐ Dad ☐ Grandparent ☐ Other: _____

Patient attends: ☐ Daycare/Preschool ☐ Homeschool ☐ Private School ☐ Public School ☐ Stays home with Caregiver

What grade is patient in? _____

Past Hospitalizations

Hospital	Reason	Admit Date	Discharge Date

Other: _____

_____

Past Surgeries

Hospital	Reason	Admit Date	Discharge Date

Other: _____

_____

I acknowledge the above information is true to the best of my knowledge.

_____ _____
Parent/Guardian Signature on behalf of patient **Date**

_____ _____
Print Name **Relation to Patient**