Date:_____

Midwest Immunology Clinic, P.A.
Patient Medical History Form (Pediatric)

Patient Name:_____ **DOB**:_____ **Age**:_____ **Nickname**:_____

Full names of Mother/ Father/ Guardian:_____

Primary Care MD:_____ **Referring MD**:_____

Main reason for today's visit:_____

Medical History

Diagnosis	Date diagnosed	Care Provider	Medications/Therapies for this diagnosis (name/dosing/prescriber)

Surgical History

Date	Surgery	Provider/Hospital

Hospitalizations (not including surgeries listed above)

Date	Reason	Provider/Hospital

Other Medications (please include vitamins, herbal supplements, and over-the-counter medications)

Medication	Dosage	Prescribing MD/NP	Medication	Dosage	Prescribing MD/NP

Current Pharmacy Name/ Location:_____

Allergies/ Reactions (include medications, pollens, foods, latex, venom, or other products)

Medication/Product	Reaction	Medication/Product	Reaction

Family History

Mother **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
Lifetime Diseases_____ [ ] **None**

Father **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
Lifetime Diseases_____ [ ] **None**

Brother/sister **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
(circle one) **Lifetime Diseases**_____ [ ] **None**

Brother/sister **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
(circle one) **Lifetime Diseases**_____ [ ] **None**

Brother/sister **Living** [ ] Yes [ ] No **If Yes, Age____ If No, Cause of Death and Age**_____
(circle one) **Lifetime Diseases**_____ [ ] **None**

Personal/ Family History

[ ] None/unknown

Has your child or have any close members in your family (**not listed above**) including your child's grandparents, aunts, and/or uncles had any of the following medical conditions?

	Self	Family	Relationship	Age Diagnosed
Recurrent infections	[ ]	[ ]		
Immune deficiencies	[ ]	[ ]		
Bleeding/clotting problems	[ ]	[ ]		
Leukemia/lymphoma	[ ]	[ ]		
Other cancers	[ ]	[ ]		
Allergies/asthma	[ ]	[ ]		
Reflux/heartburn	[ ]	[ ]		
Thyroid disease	[ ]	[ ]		
Bone/joint disease (eg, RA)	[ ]	[ ]		
Lupus	[ ]	[ ]		
Eczema/Atopic dermatitis	[ ]	[ ]		
Skin disease (eg, psoriasis)	[ ]	[ ]		
Bowel disease (eg, colitis)	[ ]	[ ]		
Heart disease/heart attack	[ ]	[ ]		
High blood pressure	[ ]	[ ]		
Lung disease (eg, COPD)	[ ]	[ ]		
Anxiety/depresion	[ ]	[ ]		
Stroke	[ ]	[ ]		
Tuberculosis	[ ]	[ ]		
Osteoporosis	[ ]	[ ]		

Current Review of Systems (please check if your child has or has recently experienced any of the following)

General: Unexplained weight loss/gain Fatigue Night sweats Fevers Hair loss Sun sensitivity

HEENT: Eye Redness Vision change (blurred/double) Ear pain Hearing loss Eye/ear drainage
Runny nose Nasal congestion Nose/mouth ulcers Sore throat Bleeding gums Thrush

Cardiac: Chest Pain Palpitations Swelling/Edema (location):_____

Respiratory: Wheezing Cough Shortness of breath Sputum production

GI: Constipation Diarrhea Abdominal pain Nausea Black stool Blood in stool/on tissue

GU: Frequent urination Painful urination Change in urine color Frequent urine infections
Irregular menses Heavy menses Menopausal symptoms (hot flashes/night sweats)

Musculoskeletal: Joint pain Joint redness Joint swelling Muscle pain Bone pain Weakness

Skin: Rash Hives Swelling Dry skin Acne Poor wound healing Warts

Neurologic: Headaches Weakness Numbness/tingling Seizures

Psychologic: Anxiety Depression Insomnia Memory loss Poor school performance Attention problems

Endocrinologic: Excessive thirst Excess urination Hair loss Hair growth Cold/heat intolerance

Other: Bruising Nosebleeds Swollen glands/nodes Neck stiffness Dental problems

Social History

With whom does your child primarily live:_____

Does your child live in multiple households:_____

Describe the household(s) where your child lives (eg, house, apartment):_____

Are there any pets: Yes No If yes, list:_____

Are there problems with: Pests_____ Rodents_____ Water damage_____

Does your child attend daycare/school:_____

If yes, where/what grade:_____

Are you (or your child's parents/guardians) employed: Yes No

If yes, where/title:_____

Does your child have smoke exposure: Yes No If yes, describe:_____

Does your child follow a special diet: Yes No If yes, what type:_____

Has your child received a blood transfusion: Yes No

If yes, date/circumstances:_____

Has your child traveled internationally: Yes No

If yes, when/where:_____

Health Maintenance

Date of last vision screening:_____ History of abnormal vision screen: Yes No

If yes, when/what was done:_____

Date of last pulmonary function test (PFTs):_____ History of abnormal PFTs: Yes No

If yes, when/what was done:_____

Date of last bone density (DEXA) scan:_____ History of abnormal DEXA scan: Yes No

If yes, when/what was done:_____

Has your child received a tuberculin (TB) skin test (eg, PPD/Mantoux): Yes No

If yes, date:_____ Result_____

Federal Race/ Ethnicity Information

In compliance with Federal regulations, Midwest Immunology Clinic collects information on race/ethnicity, country of origin and primary language for all patients we serve.

Is your child of Hispanic, Latino or Spanish origin: Yes No

What is your child's race/ethnicity (circle one):

Mexican/Mexican-American/Chicano Puerto Rican Cuban White/Caucasian Black/African-American

American Indian/Alaskan Native Asian Indian Chinese Filipino Japanese Korean Vietnamese Hmong

Native Hawaiian Guamanian/Chamorro Samoan Somali

Country of origin:_____ Primary Language:_____

Parent/ Guardian Name: _____ Date: _____

Parent/ Guardian Signature: _____