LANCASTER PEDIATRIC ASSOCIATES, LTD.

Medical History Form- Yearly Update
Patients 3 through 11 years

Patient's First/Last Name: _____ Birthdate _____

Age _____ Date _____

Please list the following: (Nurses, please enter under the "Basic Information" tab)

Primary Language:

Race: Declined to specify (circle)

Ethnicity: Declined to specify (circle)

Please review questions 5 & 6 under Academic & Social History and answer both for this year

Patient Medical History

In the past YEAR have any of the following occurred?

1. Hospitalizations? (list month, hospital and reason for hospitalization) ☐None

_____

2. Surgeries? (list month, hospital and surgery performed) ☐None

_____

3. Please list any serious injuries or accidents? (list month and nature of injury/accident) ☐None

_____

4. Any new drug, food or environmental allergies? ☐Yes ☐No (if yes list below with reaction)

_____

5. For girls: Has she started her menstrual periods? ☐Yes ☐No Are there problems with her periods? ☐Yes ☐No

_____

6. Does your child see a dentist? ☐Yes ☐No If yes, who: _____ Date of last visit: _____

Patient's First/Last Name: _____ Birthdate _____

Please **CIRCLE** any condition that is **NEW** in the past year:

Chicken pox
If Yes When? _____
Eye conditions/corrective lenses
Problems with ears or hearing
Thyroid or other endocrine problems
Chronic or recurrent skin problems (acne, eczema)
Seizures or other neurologic problems
Behavior disorders (ADD, ADHD, ODD)
Mental health concerns
Cancer
Other:

Blood transfusion
Anemia or bleeding problem
Constipation requiring office visits
Frequent abdominal pain or GERD
Diabetes
Bladder, kidney infections or other urologic problems
Frequent headaches
Chronic/serious lung disease
High blood pressure
High cholesterol

Please explain any conditions you circled above or explain any other medical conditions:

Patient's First/Last Name: _____ Birthdate _____

Patient Academic & Social History

Academic & Social History update over the last YEAR—Please Print

Daytime Status: ☐Home ☐Daycare ☐School

1. If your child has been in school, have they had any difficulties with academics? ☐Yes ☐No ☐Not applicable
2. Has he/she been placed in a special resource class? ☐Yes ☐No ☐Not applicable
3. Did he/she need to repeat last year's grade? ☐Yes ☐No ☐Not applicable
4. Has your child been diagnosed with a learning disorder within the last year? ☐Yes ☐No
5. Has your child displayed any signs of social isolation or social anxiety in the last year? ☐Yes ☐No ☐Not applicable
6. Has your child experienced any issues with bullying in the last year? ☐Yes ☐No ☐Not applicable

If you marked "yes" to 5 or 6, please hand your form directly to the nurse or to the provider that is seeing your child today

Please explain any "**yes**" answers further:

_____

_____

Household Structure

List the name anyone CURRENTLY LIVING IN THE HOUSEHOLD- include any parents, siblings , any extended family, step-family, grandparents, others	**Date of Birth**	**Relationship to Child**

What is the current family parental structure for the patient:

1.Parent's Marital Status: ☐Married, living together ☐Divorced ☐Not applicable/other(please explain below)

_____

2.Patient's custody status: ☐Joint ☐Visitation ☐Non-custodial (If visitation, or non-custodial please explain below)

_____

Patient's First/Last Name: _____ Birthdate_____

Household Environment

Please answer the following environmental questions:

1. Does anyone in the household smoke? ☐Yes ☐No

2. Does anyone at daycare smoke? ☐Yes ☐No ☐Not applicable

3. Are there firearms in the home? ☐Yes ☐No
   If yes, are the guns locked and kept separate from the ammunition?
   ☐Yes ☐No
4. Are there firearms at daycare? ☐Yes ☐No ☐Not applicable
   If yes, are the guns locked and kept separate from the ammunition?
   ☐Yes ☐No

5. Are there any pets in the home? ☐Yes ☐No
   If yes, what type?

6. Are there any pets at daycare? ☐Yes ☐No ☐Not applicable
   If yes, what type?

7. In the last year, have you worried that the food you purchased would run out before you had money to buy more? ☐Yes ☐No ☐Declined to Answer
8. In the last year, did you run out of food and not have money to purchase more?
   ☐Yes ☐No ☐Declined to Answer

If you answered yes to the **two questions above**, would you like information on community resources that can help? ☐Yes ☐No ☐Not applicable

No changes since completion of last medical history form ☐

Patient's First/Last Name: _____ Birthdate _____

Changes to Family History in the past YEAR— check all that apply. ONLY include GENETIC family members.

(If no changes, leave blank)

	Mom	Dad	Sister	Brother
Cancer				
Asthma/Other Lung Disease				
Diabetes or Other Endocrine Problems (before 50 years old)				
High Blood Pressure				
High Cholesterol				
Heart Disease (before 50 years old)				
Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease)				
Kidney Disease				
Liver Disease				
Bleeding Disorder				
Mental Illness				
Epilepsy, Convulsions, or Seizures				
Neurologic Disorder				
ADHD/ADD				
Alcohol Abuse				
Drug Abuse				
Hearing Problems/Deafness				
Vision Impairment/Eye Disorder (not including standard glasses or contacts)				
Immune Problems, Recurrent Infections, or HIV/AIDS				
Other GI Disease/Disorder				
Unexplained Sudden Death (before 50 years old)				

If no significant family history, please check here: ☐

Additional Pertinent Conditions

Explain _____