BREEN
FAMILY MEDICINE

PEDIATRIC HEALTH HISTORY FORM

Full Name: ___________________________________ Date: _______________________

Date of birth: _________________________________ Age: _______________________

How did you find us/referred by anyone: ____

ALLERGIES ▢ No allergies

ALLERGY	Allergic Reaction

MEDICATIONS

MEDICATIONS (PLEASE LIST ALL)	DOSE	TIMES PER DAY

(If you take additional medications please add to back of paper)

VACCINE HISTORY

Immunizations current?	YES NO

SURGICAL HISTORY

Type *(specify left/right)*	Date

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Asthma			
Cancer *(type)*: _______________________			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes			

SOCIAL HISTORY

Marital status of parents: ▢ Married ▢ Divorced ▢Separated	
Do you have siblings: Y N	If so, how many:
Currently living with:	

TOBACCO USE	Exposed to second hand smoke? Y N Exposed to vaping? Y N Currently smoking? Y N
ALCOHOL/DRUG USE	Exposed to alcohol: Y N Sexually Active: Y N; concerned about STD's?
SLEEP	How many hours, on average, do you sleep at night:
DIET	How would you rate your diet? ▢ Good ▢ Fair ▢ Poor
SAFETY	Do you wear the following: Bike helmet Y N, Seat Belt Y N
Working smoke detectors in home? Y N, If you have guns at home, are they locked up? Y N	
HOBBIES:	
PETS:	

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurologist		
Nephrologist (kidney)		
Ophthalmologist (eye)		

REVIEW OF SYSTEMS

	CONSTITUTION
	Activity changes
	Appetite changes
	Chills
	Excessive sweating
	Fatigue
	Unexpected weight loss

	HEAD, EAR, NOSE & THROAT
	Sinus congestion
	Dental problems
	Ear pain/discharge
	Facial swelling
	Hearing loss
	Mouth sores
	Nose bleeds
	Postnasal drainage
	Sore throat
	Ringing in ears (tinnitus)
	Trouble swallowing
	Sneezing

	EYES
	Eye discharge
	Eye itching
	Eye pain
	Sensitivity to light
	Visual disturbances

	RESPIRATORY
	Apnea
	Chest tightness
	Choking
	Cough
	Asthma
	Shortness of breath
	Wheezing

	CARDIOVASCULAR
	Chest pain
	Leg swelling
	Palpitations

	GASTROINTESTINAL
	Abdominal distention
	Abdominal pain
	Rectal pain
	Blood in stool
	Constipation
	Diarrhea
	Nausea
	Vomiting
	Acid reflux/heart burn

	ENDOCRINE
	Cold intolerance
	Heat intolerance
	Increased thirst (polydipsia)
	Increased hunger (polyphagia)
	Increased urination (polyuria)

	GENITOURINARY
	Difficulty urinating
	Pain with urination
	Bed wetting
	Flank pain
	Frequency
	Genital sores
	Blood in urine
	Penile discharge/pain
	Scrotal swelling/pain
	Decreased urination
	Decreased concentration

	SKIN
	Color changes
	Abnormal moles
	Rash
	Wound

	ALLERGY/IMMUNO
	Environmental allergies
	Food allergies
	Immunocompromised

	NEUROLOGIC
	Dizziness
	Facial asymmetry
	Headaches
	Numbness
	Seizures
	Speech difficulty
	Passing out (syncope)
	Tremors
	Weakness

	MEN'S HEALTH
	Erectile dysfunction
	Loss of libido

	PSYCIATRIC
	Irritability
	Confusion
	Anxiety
	Depression
	Insomnia
	Self-injury
	Suicidal thoughts
	Hyperactivity

Family Medical History

▫ adopted

✓ CHECK ALL THAT APPLY	Mother	Father	Brother	Sister	MGM	MGF	PGM	PGF
Alcohol/Drug Abuse								
Asthma								
Depression/Anxiety								
Diabetes								
High cholesterol								
High blood pressure								
Thyroid disease								

Cancer (specify type & family member): ______________________