Bee Well Pediatrics

Medical History

Current Medications:

	Medication Name	Dosage/Strength	Frequency	Purpose (optional)
1				

List of Surgeries:

	Surgery Type	Date of Surgery	Location	Doctor Name
1				

Emergency Room or Urgent Care Visits (Last 6 Months)

	Date of Visit	Facility Name	City	Reason for Visit
1				

Patient and Family Health History

Patient Medical History

- ☐ Asthma
- ☐ Allergies
- ☐ Down Syndrome
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Heart Disease
- ☐ Seizures/Epilepsy
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mental Health Disorders
- ☐ No previous medical history

Comments:

Family Medical History

	Mother	Father	Sibling	Maternal GP	Paternal GP
Asthma	☐	☐	☐	☐	☐
Down Syndrome	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Diabetes Type I	☐	☐	☐	☐	☐
Diabetes Type II	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Mental Health Disorders	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

Comments:

Pediatric Social History Questions

Living Environment

Who does the patient live with?

Are there any pets in the home?
◯ Yes ◯ No

If yes, please specify types of pets:

Lifestyle

Does the patient attend daycare, preschool, or school?
◯ Yes ◯ No

If yes, name of the facility/school:

How many hours per day does the patient spend on screens (TV, phone, tablet, etc.)?

Does the patient participate in sports or physical activities?
◯ Yes ◯ No

If yes, which activities/sports?

Does the patient have a regular bedtime routine?
◯ Yes ◯ No

If yes, what time do they typically go to bed?

Safety

Does the patient use a car seat, booster seat, or seat belt as required by age/weight?
◯ Yes ◯ No

Are there any firearms in the home?
◯ Yes ◯ No

If yes, are they secured in a locked location?
◯ Yes ◯ No

Substance Exposure (if age-appropriate)

Has the patient been exposed to drugs or alcohol?
◯ Yes ◯ No

Mental and Emotional Health

Has the patient experienced any bullying at school or online?
◯ Yes ◯ No

Does the patient have difficulty making or maintaining friendships?
◯ Yes ◯ No

Does the patient have any concerns about their mental health (e.g., sadness, anxiety)
◯ Yes ◯ No

Family and Social Support

Does the family have access to sufficient food, housing, and other necessities?

◯ Yes ◯ No

Are there any family stressors affecting the patient (e.g., divorce, financial difficulties)?

◯ Yes ◯ No

Detailed Birth History (For Children 6 and Under)

Birth Details

Place of Birth (City, State, Hospital/Other Location):

Type of Delivery:

Type of Feeding:

Birth Statistics

Birth Weight:

Length:

Was the patient born full term?

◯ Yes ◯ No

If no, how many weeks at birth?

Complications & NICU Stay

Any complications during pregnancy or delivery?

◯ Yes ◯ No

If yes, explain:

NICU Stay?

◯ Yes ◯ No

If yes, how long and what for:

Consent and Confirmation:

• This form confirms that all information provided is accurate and complete. The parent or guardian verifies the accuracy of the information by signing below and consents to the medical use of this data for care purposes.

Parent or Guardian Name:

Relationship to Patient:

Signature of Parent/Guardian:

Date