BooneHealth
BOONE MEDICAL GROUP

Pediatric Medical History Questionnaire

Name (Last, First, M.I.) _____(Circle) Male Female_____

Date of Birth ___/___/___/___ Age:_____ SSN:_____

Home Phone	Preferred Pharmacy Name and Location
Cell Phone	Primary Dentist
Address	Email Address

PARENT(S) INFORMATION

Name person completing form_____Relationship to patient_____

Mother's full name _____ Father's full name_____ Birthdate: _____

Mom SSN & Phone#_____ Father SSN & Phone#_____

Guardian full name_____ Emergency Contact Name & Phone #_____

Who is primary caregiver?_____Child lives with who?_____

CHIEF COMPLAINT

What is the primary concern today?

Check here if you would like to discuss anxiety or depression or behavior changes in your child with the MD ☐

Describe the course of this illness: ☐ Stable ☐ Progressive ☐ Improving

List symptoms of today's illness:

Rash Y_ N_ Pain Y_ N_ Other _____

Headache Y_ N_ Fever Y_ N_ _____

Vomiting Y_ N_ What was the highest temperature?

Diarrhea Y_ N_ Was Tylenol or ibuprofen given? When?

MEDICAL HISTORY - circle any additional medical symptoms or diagnoses that apply for your child.

Neurological: Spina bifida Dizziness Seizures Headaches such as migraine

Ears: Frequent ear infections Ear tubes Trouble hearing

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Throat: Frequent strep throat Tonsil and/or Adenoid removal? Y____ N_____

Endocrine Diabetes Fatigue Weight gain or loss Thyroid

Growth: Failure to thrive Short stature

Lungs: Asthma RSV Bronchitis Shortness of breath Pneumonia

Heart: Congenital heart disease Irregular heart beat Chest pains High blood pressure
Passing Out Fatigue

Blood: Anemia Low platelets Low white count Unexplained bleeding Unexplained bruising

Stomach/Intestines: Abdominal pain Inflammatory bowel disease Celiac disease
Constipation Reflux Frequent diarrhea Vomiting

Bladder/Kidney: Urinary tract infections

Genitalia: Undescended testicles Hypospadias Vaginal stenosis Vaginal discharge

Muscles/Joints: Increased joint flexibility Poor coordination Arthritis Joint dislocations Muscle pain
Contracture Joint pain

Skeletal: Low bone density Scoliosis Abnormal bone age Fractures
Pectus excavatum (sunken chest) Pectus carinatum (pigeon chest)

Other: Developmental concerns Speech concerns

ALLERGIES Yes No

List drug allergy & other pertinent allergies such as bees, latex, adhesive, shellfish, food

1.
2.
3.
4.

PHARMACY AND MEDICATION LIST *Please list all current meds below.*

Prescription meds. Please list both long term and those used for this episode.

Non-prescription meds. Please list meds used regularly and for this episode.

Name:	**Using Currently:**
_____	Yes No
_____	Yes No
_____	Yes No
_____	Yes No

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SURGERIES AND HOSPITALIZATIONS

Type	Hospital/Doctor	Date

FAMILY HISTORY

Does your child have any relatives with the following problems? Check off if problem in family history and write in relationship next to the problem.

☐ Asthma	☐ Learning issues:
☐ Anemia:	☐ Limb defects:
☐ Arthritis:	☐ Mental retardation:
☐ Autism spectrum disorder:	☐ Mental illness:
☐ Birth defect:	☐ Metabolic problem:
☐ Blindness or eye disorder:	☐ Muscular dystrophy:
☐ Bone disorder:	☐ Multiple miscarriages:
☐ Cancer:	☐ Neurofibromatosis:
☐ Chromosome abnormality:	☐ Neurologic disorder:
☐ Cleft lip/palate:	☐ Seizures:
☐ Clots (blood):	☐ Short stature (<5'0"):
☐ Cystic fibrosis:	☐ Skeletal abnormality:
☐ Diabetes	☐ Skin disease:
☐ Heart defect:	☐ Spinal muscular atrophy:
☐ Hemophilia:	☐ Spina bifida:
☐ Huntington disease:	☐ Strokes Age of occurrence
☐ Hydrocephalus:	☐ Tall stature (>6'0")
☐ High blood pressure:	☐ Urinary tract abnormality:
☐ Infertile:	☐ Heart attack Age of occurrence
☐ Intellectual disability:	☐ Kidney disease
☐ Other	

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Smoke exposure: (does patient ?) smoke vape chew tobacco exposure to 2nd hand smoke		
Alcohol use:	Type	Frequency
Drug use:	Type	Frequency
Guns:	In the home?	Locked?
Car safety:	Car seat use?	Seat belt use?

IMMUNIZATIONS	**Please attach vaccine records**
Year	**Immunization**
Last yr__ this year___	Influenza
	Tetanus
	Other (please specify)

BIRTH HISTORY	
Length:	Gestational age:
Weight:	Delivery method:
Head circumference:	Duration of labor:
Discharge weight:	Feeding method:

HOSPITAL INFORMATION		
Days spent in the hospital	Hospital Name	
Did your child spend time in the NICU (Neonatal intensive care unit)?	☐ Yes	☐ No
Please Explain:		

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Travel and Exposure Questionnaire

Have you traveled outside the U.S. in the last month?

YES NO

Have you had contact with someone with a communicable disease in the last month?

YES NO UNKNOWN

If yes, please circle:

Chicken pox Cholera Cold Ebola Enterovirus Influenza
Measles Meningitis MERS Tuberculosis Unidentified

Other (Please Comment)_____Exposure Date:_____

Have symptoms below occurred in the last week? If yes, please circle:

Abdominal Pain Cough Diarrhea Fever Muscle Pain

Severe Headache Bruising or Bleeding Vomiting Weakness Rash