Inter Island Medical Center
Pediatric Medical History

Last Name________________________ **First Name_________________** **M.I._____**
Date of Birth________________________ **Social Security Number_________________**
Parent / Guardian_____________________________

Others in Household:

Name	Age	Relationship

Please Provide Copy of immunization history.

Allergies: Medications, Seasonal, other

Hospitalizations:

Reason	Date

Family History: Is there any family history of…

Anemia	Yes	No
Diabetes	Yes	No
Cancer (Type ______________________)	Yes	No
Heart Disease / Heart Attack	Yes	No
Lung Disease	Yes	No
Disease of Nervous system (seizures, etc.)	Yes	No
Allergies (asthma, hay fever, etc)	Yes	No
Other inherited diseases _______________	Yes	No

Social History:

Any daycare or school problems	Yes	No
Family Problems (siblings, divorce, death)	Yes	No
Anger / Discipline problems	Yes	No

Physical History: Has your child had any of the following…

Asthma	Yes	No
Hay Fever	Yes	No
Ear infections	Yes	No
Eye problems	Yes	No
Frequent sore throats	Yes	No
Cough	Yes	No
Wheezing	Yes	No
Chest pain	Yes	No
Stomach pains	Yes	No
Poor appetite	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Urinary or menstrual problems	Yes	No
Complaints of pain	Yes	No
Growth or weight concerns	Yes	No
Speech problems	Yes	No
Hearing problems	Yes	No
Behavior problems	Yes	No
Frequent accidents/injuries	Yes	No

Parent / Guardian Signature ____ Date____________