**Child’s Past and Current Medical History**

**Care Provider to Complete**

**Date of Service:** Click or tap here to enter text.

1. **Child’s medical history**
2. **Well Child/General Pediatric history**

|  |  |
| --- | --- |
| **History obtained/provided by:** |  |
| **Primary care provider:**  |  |
| **Immunizations up-to-date** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Pregnancy/birth issues** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Chronic/active disease** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Allergies** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Hospitalizations** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Surgeries** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Trauma/injury** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |  |
| **Specify:**   |

1. **Medications**

|  |  |
| --- | --- |
| **History obtained/provided by:** |  |
| **Name of medication**  | **Dosage** | **Purpose** | **Prescribing clinician**  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Genitourinary history**

|  |
| --- |
| **History obtained/provided by:**  |
| **Genital pain/lesions/bleeding/discharge** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Rectal pain/lesions/bleeding/discharge** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Prior urinary tract infection** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Prior sexually acquired infection** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **First Period** | **Yes** [ ]  **No** [ ]  | **Age**  |  | **LMP** |  |
| **Describe any significant genitourinary and/or reproductive health history:**  |

1. **Developmental and/or educational history**

|  |
| --- |
| **History obtained/provided by:**  |
| **Developmental concerns** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Educational concerns** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe any significant developmental and/or educational history:**  |

1. **Behavioral and mental health history**

|  |
| --- |
| **History obtained/provided by:** |
| **Currently receiving mental health treatment?**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Reason for mental health services:**  |  |
| **Clinician and/or practice** |  |
| **Sleep disturbance** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Poor concentration** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Anxiety** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Hypervigilance/exaggerated startle** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Re-experiencing/nightmares/flashbacks** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Avoidance/withdrawal** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Eating disorder** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Enuresis/encopresis** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Self-injurious behavior** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Hyperactivity/impulsivity** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Anger outbursts/irritability** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Depressed mood** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Suicidal behavior** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Sexualized behavior problems** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |

|  |
| --- |
|  **History obtained/provided by:**  |
| **Describe any significant behavioral history:**  |

1. **Family medical history** *Document the health history of parents’ and immediate family*

|  |  |
| --- | --- |
| **History obtained/provided by:** |  |
| **Significant family history** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe significant family history:**  |

1. **Psychosocial history**

|  |
| --- |
| **History obtained/provided by:**  |
| **Prior CPS involvement** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Prior LE/criminal history** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Domestic violence** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Trauma exposure** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Substance misuse/disorder** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Mental health concerns/diagnosis:**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe any significant psychosocial history:**  |

1. **Review of systems**

**Are there any significant concerns?**

|  |  |
| --- | --- |
| **History obtained/provided by:** |  |
| **General** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **GI** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Dental** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Respiratory**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Hearing** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Musc/Skel** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Visions** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **GU** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **ENT** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Endo**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Ophthalmology**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Heme/Lymph** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Skin** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Neuro**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **CV**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Psych**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe significant findings:**  |