CROSS TRAILS MEDICAL CENTER
PATIENT HISTORY
PEDIATRIC LIFECYCLE
(Ages Birth to 11 years)

Date Completed: _____/_____/_____

PLEASE FILL IN ALL INFORMATION AS COMPLETE AS POSSIBLE.

NAME: ________________________________ DATE OF BIRTH: _____/_____/_____

Current Medications: ____

Allergies: ____

PAST MEDICAL HISTORY:

Previous Surgery: ____

Previous Illness: ____

Previous Hospitalizations: ____

Birth History: Circle appropriate response: **Vaginal or Cesarean Delivery**
Premature or Term
Any complications with birth: Yes / No
If yes, describe: ____

Feeding History: Circle appropriate response: Bottle or Breast
Approximate number of ounces per feeding: _________ Feedings per day: _________

If using a bottle, does the child receive a bottle at bedtime: Yes / No
What is in the bedtime bottle: ____
Do you prop the bottle up while the baby falls asleep: Yes / No

SOCIAL HISTORY:

Number of siblings: ______ (brothers) ______ (sisters)

Any exposure to: _______ alcohol _______ tobacco _______ other drugs
Type of water: _______ city _______ well / spring

FAMILY HISTORY:

Age: Mother _______ Health: good fair poor If deceased, state cause of death _______________
Father _______ Health: good fair poor If deceased, state cause of death _______________

REVIEW OF SYSTEMS: (CIRCLE "YES" or "NO" AS APPROPRIATE)

HEENT		**RESPIRATORY**	
Frequent Headaches	**Yes / No**	**Asthma**	**Yes / No**
Hearing Problems	**Yes / No**	**Bronchitis**	**Yes / No**
Vision Problems	**Yes / No**	**Pneumonia**	**Yes / No**
Frequent Ear Infections	**Yes / No**	**Tuberculosis**	**Yes / No**
Allergy Symptoms	**Yes / No**	**Shortness of Breath**	**Yes / No**
Sinus Infections	**Yes / No**	**Persistent Cough**	**Yes / No**
Other ______________________________		**Other ______________________________**	
____________________________________		____________________________________	

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CARDIOVASCULAR

Heart Problems	Yes / No
Irregular Heartbeat	Yes / No
Heart Murmur	Yes / No

Other ______________________________
____

MUSCULOSKELETAL

Joint Pain	Yes / No
Deformity	Yes / No
Sports Injury	Yes / No

Other ______________________________
____

ENDOCRINE

Diabetes	Yes / No
Excessive Thirst	Yes / No
Excessive Urination	Yes / No
Thyroid Problems	Yes / No

Other ______________________________
____

GASTROINTESTINAL

Liver Disease	Yes / No
Hepatitis	Yes / No
Pancreas Problems	Yes / No
Difficulty Swallowing	Yes / No
Difficulty Sucking	Yes / No
Vomiting	Yes / No
Colic	Yes / No
Poor Appetite	Yes / No
Blood in Bowel Movement	Yes / No
Diarrhea	Yes / No
Constipation	Yes / No

Other ______________________________
____

PREVENTION

Exercise	Yes / No
Avoid excessive sugars / sweets	Yes / No
Use child safety seats	Yes / No
Use seat belts	Yes / No
Wear helmet when riding a bicycle	Yes / No
Immunizations up to date	*Yes / No*
Any concern regarding abuse	*Yes / No*
Receive fluoride treatments	*Yes / No*

NEUROLOGICAL

Epilepsy	Yes / No
Seizure	Yes / No
Fainting	Yes / No

Other ______________________________
____

PSYCHOLOGICAL

Hyperactivity	Yes / No
Depression	Yes / No
Counseling Received	Yes / No
Phobias	Yes / No

Other ______________________________
____

SKIN

Itching	Yes / No
Eczema	Yes / No
Moles	Yes / No
Excessive Sun Exposure	Yes / No

Other ______________________________
____

GENITOURINARY

Urinary Tract Infection	Yes / No
Kidney Problems	Yes / No
HIV / AIDS	Yes / No

Other ______________________________
____

HEMATOLOGICAL

Sickle Cell Trait	Yes / No
Sickle Cell Anemia	Yes / No
Bleeding Disorder	Yes / No
Cancer	Yes / No
Anemia	*Yes / No*

Other ______________________________

Please list any other healthcare providers your child has seen:

____
____
____
____

Comments ____

Patient Name: ______________________________

Parent/Guardian Name:______________________

Parent/Guardian Signature: __________________

(rev. 1/14/15)