Covenant Clinic
Wheaton Franciscan Healthcare **Pediatric History**

Date Received
(for office use only)

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Name _____

Address _____

Who completed this form? ❑ Patient ❑ Spouse ❑ Other (specify) _____

Telephone No. _____ Work Telephone No. _____

Sex: ❑ Male ❑ Female Date of Birth: (month/day/year) _____ Referred by _____

MEDICATIONS:

Medications Currently Being Taken _____

_____

_____

_____

Allergies _____

_____

_____

_____

_____

Do you use any over-the-counter medications? .... ❑ Yes ❑ No List all _____

_____

Do you have any allergies to medications? ..... ❑ Yes ❑ No List all _____

_____

PAST MEDICAL HISTORY - Review Of Systems

Indicate whether you have ever had a medical problem and/or surgery related to each of the following by placing a check "✓" in the appropriate box(es). If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. **CIRCLE** the appropriate choice when multiple choices are listed in a question.

	No Problem	Medical Problem	Surgery	Year(s) of Surgery	Seen By Specialist	Describe
1. Head (injuries, loss of consciousness, concussion, headaches, migraines)	❑	❑	❑	____	Y / N	_____
2. Eyes (crossed eyes, lazy eyes, impaired vision)	❑	❑	❑	____	Y / N	_____
3. Ears (impaired hearing)	❑	❑	❑	____	Y / N	_____
4. Nose, sinuses (asthma, hay fever)	❑	❑	❑	___	Y / N	_____
5. Mouth, throat, tonsils, teeth (Last dental visit_____)	❑	❑	❑	____	Y / N	_____
6. Thyroid or parathyroid glands (goiter)	❑	❑	❑	____	Y / N	_____

	No Problem	Medical Problem	Surgery	Year(s) of Surgery	Seen By Specialist	Describe
7. Heart valves or abnormal heart rhythm	❑	❑	❑	____	Y / N	_____
8. Congenital heart disease	❑	❑	❑	____	Y / N	_____
9. Arteries or veins	❑	❑	❑	____	Y / N	_____
10. Lungs (asthma, pneumonia)	❑	❑	❑	____	Y / N	_____
11. Esophagus or stomach (ulcer, vomiting)	❑	❑	❑	____	Y / N	_____
12. Bowel (small or larger intestine, colitis)	❑	❑	❑	____	Y / N	_____
13. Appendix	❑	❑	❑	____	Y / N	_____
14. Rectum (hemorrhoids, rectal bleeding, change in bowel habits)	❑	❑	❑	____	Y / N	_____
15. Liver or gallbladder (including hepatitis)	❑	❑	❑	____	Y / N	_____
16. Pancreas	❑	❑	❑	____	Y / N	_____
17. Hernia	❑	❑	❑	____	Y / N	_____
18. Lymph nodes or spleen	❑	❑	❑	____	Y / N	_____
19. Kidneys, bladder (urinary tract infection, bed wetting)	❑	❑	❑	____	Y / N	_____
20. Back, neck or spine	❑	❑	❑	____	Y / N	_____
21. Bones, joints or muscles	❑	❑	❑	____	Y / N	_____
22. Brain (speech problems, headaches, seizures, convulsions)	❑	❑	❑	____	Y / N	_____
23. Skin (hives, eczema, jaundice, frequent sores)	❑	❑	❑	____	Y / N	_____
24. Breasts	❑	❑	❑	____	Y / N	_____
25. **Males:** prostate, testes	❑	❑	❑	____	Y / N	_____
26. **Female:** Uterus, tubes, ovaries	❑	❑	❑	____	Y / N	_____
27. Learning or school problems	❑	❑	❑	____	Y / N	_____

Has patient ever been hospitalized? ❑ Yes ❑ No → If yes, specify: _____
Has patient had any serious injuries and/or broken bones? ❑ Yes ❑ No → Describe: _____
Has patient ever received a blood transfusion? ❑ Unknown ❑ Yes ❑ No → Approximate years(s): _____
Has patient ever traveled or lived outside the United States or Canada? ❑ Yes ❑ No → When and where: _____
While mother was pregnant with patient, did she use: ❑ Tobacco ❑ Recreational Drugs ❑ Alcohol ❑ Medications
Did mother have: ❑ Bleeding ❑ Transfusion ❑ High Blood Pressure ❑ Other problems: _____
Delivery History of Patient: ❑ Vaginal ❑ C-Section (elective or emergency) ❑ Breech ❑ Full-term ❑ Pre-term ❑ Breathing Problems
❑ Delayed Discharge ❑ Multiple Birth ❑ Other complications: _____ Birth Weight: _____

Has Patient been <u>IMMUNIZED</u> against the following? If yes, indicate the approximate year it was last given:

DPT	❑ Unknown	❑ Yes	❑ No	(Year _____)	Oral Polio	❑ Unknown	❑ Yes	❑ No	(Year _____)
DT Booster	❑ Unknown	❑ Yes	❑ No	(Year _____)	HIB	❑ Unknown	❑ Yes	❑ No	(Year _____)
Measles	❑ Unknown	❑ Yes	❑ No	(Year _____)	HepB	❑ Unknown	❑ Yes	❑ No	(Year _____)
Mumps	❑ Unknown	❑ Yes	❑ No	(Year _____)	TB Skin Test (❑ Pos ❑ Neg)	❑ Unknown	❑ Yes	❑ No	(Year _____)
Rubella	❑ Unknown	❑ Yes	❑ No	(Year _____)	BCG (if applicable)	❑ Unknown	❑ Yes	❑ No	(Year _____)
Other (includes pneumovax and influenza): _____					Chicken Pox	❑ Unknown	❑ Yes	❑ No	(Year _____)

FAMILY HISTORY

Are you adopted? ..... ❑ Yes ❑ No

Place a check mark "✓" in the appropriate boxes to identify all illnesses/conditions **which you know have occurred** in your **blood relatives**.

	FAMILY MEMBERS						
	Grandparents Number Alive / Deceased _____/_____ Approx. Ages _____ Ages at Death _____ Causes of Death _____ _____	Father Alive / Deceased _____/_____ Approx. Age _____ Age at Death _____ Cause of Death _____ _____	Mother Alive / Deceased _____/_____ Approx. Age _____ Age at Death _____ Cause of Death _____ _____	Brothers Number Alive / Deceased _____/_____ Approx. Ages _____ Ages at Death _____ Causes of Death _____ _____	Sisters Number Alive / Deceased _____/_____ Approx. Ages _____ Ages at Death _____ Causes of Death _____ _____	Sons Number Alive / Deceased _____/_____ Approx. Ages _____ Ages at Death _____ Causes of Death _____ _____	Daughters Number Alive / Deceased _____/_____ Approx. Ages _____ Ages at Death _____ Causes of Death _____ _____
Illness/Condition (circle which one)							
Cancer (describe the type of cancer for each person)							
Heart Disease							
Diabetes							
High Blood Pressure, High Cholesterol, Triglycerides							
Liver Disease							
Alcohol or Drug Abuse							
Anxiety, Depression or Psychiatric Illness							
Tuberculosis (TB)							
Anesthesia Complications							
Genetic or Inherited Disorder							
Epilepsy/Seizures, Stroke/TIA							
Asthma, Hives, Hayfever							
Blood Disease							

SELF-CARE/HOME ENVIRONMENT ASSESSMENT

Does patient have difficulty performing by himself/herself:

Eating ..... ❑ Yes ❑ No
Bathing ..... ❑ Yes ❑ No
Dressing ..... ❑ Yes ❑ No
Walking ..... ❑ Yes ❑ No
Using Toilet ..... ❑ Yes ❑ No

Does patient have any special dietary needs? ❑ Yes ❑ No → Describe: _____

What is patient's current living arrangement? ❑ House ❑ Apartment ❑ Nursing Care Facility ❑ Other

Does Patient live: ❑ Alone ❑ With Spouse/Family ❑ With others-describe: _____

List family or friends able to prove assistance with patient's homecare needs if he/she should ever require such assistance: _____

_____

For Medical Team Use Only: _____

_____

Home: Does patient's home have: Pets ❑ Yes ❑ No; Smoke Detectors ❑ Yes ❑ No; Firearms ❑ Yes ❑ No; Passive Smoke ❑ Yes ❑ No; Well Water ❑ Yes ❑ No

Does patient use: Bike Helmets ❑ Yes ❑ No; Car Seat/Seat Belt ❑ Yes ❑ No

Family: Is there anything we should know about patient's family situation which will help us provide care? _____

Are there any issues relating to patient's guardianship/custody? ❑ Yes ❑ No If yes, identify: _____

Are there spiritual/cultural practices which need to be considered? ❑ Yes ❑ No Describe: _____

Identify community resources used by patient or family: _____

Are there financial concerns relating to patient's visit/hospitalization? ❑ Yes ❑ No If yes, identify: _____

Education/School: Does patient attend daycare or school? ❑ Yes ❑ No Describe patient's daycare/school setting: _____

Daycare/School Provider: _____ Days of school missed in past year: _____ Current year in school: _____

Has patient ever left home/school without permission for any length of time? ❑ Yes ❑ No

Routines: What comfort measures help decrease stress for patient (blanket, toy, pacifier)? _____

How is patient disciplined? _____ How would you describe patient's personality/termperament? _____

How does patient like to spend free time (play, activities)? _____

Culture/Religion: Do you have any cultural or religious beliefs that will affect the patient's health care? ❑ Yes ❑ No → _____

Advanced Directives: Does the patient have a living will or durable power of attorney? ❑ Yes ❑ No

Reviewed by _____ Date _____

Updated by _____ Date _____

Updated by _____ Date _____