MADISON
PRIMARY CARE

Personal Hx – Birth to Age 12

Patient Name: _____

Drug and Food Allergies and Indicate Reaction: _____

Reason for Today's Visit: _____

Last doctor: _____ Reason for leaving: _____

Other doctors/specialists involved in your care: _____

Child's dentist and last visit: _____

Brush teeth at least twice a day? _____

Any history of blood transfusions? ☐ Yes ☐ No

Any recent infection, illness or injury? _____

Race / Culture: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Other

Where does child live? (house , apartment, etc.) _____

Who does child live with? (include all) _____

Does child have WIC support? ☐ Yes ☐ No Is child exposed to secondhand smoke at home? ☐ Yes ☐ No

Has your child been exposed to lead (old home, peeling paint etc.)? _____

What is your home water source? ☐ City Water ☐ Well Water ☐ Other: _____

Does child use a car seat / seatbelt? ☐ Yes ☐ No

Does child use a helmet for biking, skateboarding, etc? ☐ Yes ☐ No

Religious Preference: _____

Is child enrolled in: ☐ Daycare ☐ Preschool ☐ Stays at Home
☐ Public School ☐ Private School ☐ Home School ☐ School Grade: _____

Name of Daycare / Preschool / School: _____

How are your child's grades in school? _____

Is your child having any school problems? _____

Birth Hx

Is your child a member of your family by: ☐ Birth ☐ Adoption ☐ Step-Child ☐ Other: _____

Birth Weight: _____ Born prematurely? ☐ Yes ☐ No

Vaginal Delivery? ☐ Yes ☐ No C-Section Delivery? ☐ Yes ☐ No

Were there any complications during the pregnancy, delivery or newborn hospitalization? ☐ Yes ☐ No

If yes, please describe: _____

Develop-ment

At what age did your child:

Sit Alone: _____ Walk Alone: _____

Start Talking: _____ Potty Trained: _____

Start Reading: _____ 1st Menses for girls: _____

Nutrition

Infants: ☐ Breastfeeding ☐ Formula

Indicate how many ounces and how often: _____

Indicate if your infant is taking any cereal/solids: _____

Any juice/how many ounces per day: _____

Children: ☐ Whole milk ☐ 2% milk ☐ Skim milk

Indicate how many ounces and how often: _____

Any juice/soda, indicate how many ounces per day: _____

Does your child get adequate servings of? (Check off all that apply):

☐ Dairy ☐ Meat ☐ Fruit ☐ Vegetables ☐ Carbohydrates ☐ Fats

Are you concerned about your child's weight? _____

Activities/ Hobbies

How many hours a day does your child:
Watch TV _____ Use the Computer ____ Play Video Games _____ Read _____ Exercise/Play Outside _____
List all sports your child is involved with: _____
Are all safety measures and protective equipment used? ☐ Yes ☐ No _____
List any other activities your child does for fun: _____

Risky Behaviors

Has your child been involved with any of the following (Check all that apply):
☐ Drugs ☐ Alcohol ☐ Smoking ☐ Sexual Activity ☐ History of Abuse ☐ Guns ☐ Gangs

Past Medical Hx

Does child have a **Medical History** of *(check all that apply)*:

☐ Anemia	☐ Heart Disease	☐ Hepatitis
☐ Arthritis	☐ Hypertension	☐ Psychiatric Disorder
☐ Asthma	☐ Renal / Kidney Disease	☐ Peptic Ulcer
☐ Allergic Rhinitis	☐ Migraine Headaches	☐ Eczema
☐ Cancer	☐ Thyroid Disorders	☐ Other _____
☐ Diabetes Mellitus	☐ Tuberculosis	☐ Other _____
☐ Seizure Disorder	☐ HIV Infection	

Surgery/Hospitalization

Please list any **Surgeries/Hospitalization** that the child has had:

Surgery/Hospitalization/Injury	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Does child have a **FAMILY HISTORY** of *(check all that apply and indicate your relationship to the person affected)*:

☐ Anemia _____	☐ Glaucoma _____	☐ HIV Infection_____
☐ Arthritis _____	☐ Heart Attack _____	☐ Hepatitis _____
☐ Asthma _____	☐ Heart Disease _____	☐ Psychiatric Disorder _____
☐ Allergic Rhinitis _____	☐ Hypertension _____	☐ Peptic Ulcer _____
☐ Cancer _____	☐ Renal / Kidney Disease _____	☐ Eczema _____
☐ High Cholesterol _____	☐ Stroke Syndrome _____	☐ Substance Abuse_____
☐ Diabetes Mellitus _____	☐ Migraine Headaches _____	☐ Birth Defects _____
☐ Seizure Disorder _____	☐ Thyroid Disorders _____	☐ Genetic Disease _____
	☐ Tuberculosis _____	

Medications

Please list any **medications** that your child is currently taking:

Medications/Vitamins	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems

Please check the symptoms below that you have persistent problems with or are concerned about:

GENERAL

☐ Fever ☐ Chills ☐ Feeling Tired
☐ Weakness ☐ Weight Loss ☐ Weight Gain

SKIN/HAIR/NAILS/LYMPH

☐ Change in Skin Color ☐ Easy Bruising ☐ Pitted Nails
☐ Dry Skin ☐ Skin Lesions ☐ Mole Changes
☐ Rash ☐ Hair Symptoms ☐ Lesions
☐ Itching ☐ Fingernail Discoloration ☐ Swollen Lymph Nodes

JOINTS/MUSCLES

☐ Muscle Aches ☐ Localized Joint Stiffness ☐ Other Pain:
☐ Joint Pain, Localized ☐ Muscle Weakness _____
☐ Localized Joint Swelling ☐ Muscle Cramps

ENDOCRINE SYSTEM

☐ Recent Weight Change ☐ Tremors ☐ Excessive Hunger
☐ Temperature Intolerance ☐ Excessive Thirst ☐ Excessive Urination

EYES

☐ Blurry Vision ☐ Eye Pain ☐ Mucous-Like Drainage
☐ Double Vision ☐ Watery Drainage

EARS / NOSE / MOUTH / THROAT

☐ Ear Pain ☐ Nasal Drainage/Mucous ☐ Change in Voice
☐ Trouble Hearing ☐ Nasal Stuffiness ☐ Jaw Pain
☐ Ringing in Ears ☐ Nosebleeds ☐ Facial/Sinus Pressure
☐ Ear Drainage ☐ Snoring ☐ Tooth Ache
☐ Sneezing ☐ Sore Throat ☐ Bleeding Gums
☐ Clear Nasal Drainage ☐ Difficult Swallowing ☐ Mouth Sores

BREAST

☐ Breast Lump ☐ Breast Pain (females)

RESPIRATORY SYSTEM

☐ Cough ☐ Exposed to TB ☐ Coughing Up Sputum
☐ Coughing up Blood ☐ Shortness of Breath
☐ Night Sweats ☐ Trouble Sleeping Flat

CARDIOVASCULAR SYSTEM

☐ Palpitations ☐ Difficulty Breathing
☐ Chest Pain ☐ Soft Tissue Swelling

GASTROINTESTINAL SYSTEM

☐ Appetite ☐ Heartburn ☐ Constipation
☐ Difficulty Swallowing ☐ Flatulence (Gas) ☐ Vomiting
☐ Nausea ☐ Abdominal Pain ☐ Stool Changes
☐ Belching ☐ Diarrhea ☐ Bloody Stools
☐ Black Stools

GENITOURINARY SYSTEM

☐ Decreased Urine Volume ☐ Urinary Loss of Control
☐ Pain during Urination
☐ Blood in Urine
☐ Changes in Urinary Habits

GENITOURINARY SYSTEM – *Females Only:*

☐ Vaginal Discharge ☐ Abnormal Menses Frequency ☐ Severe Menstrual Pain
☐ Vulvar Itching/Burning ☐ Abnormal Menses Duration ☐ Date of last Menstruation:
☐ Age at first period: _____ ☐ Heavy Bleeding _____

Review of Systems – continued

GENITOURINARY SYSTEM – *Males Only:*

☐ Testicle Symptoms
☐ Blood in Semen
☐ Abnormal Urethral Discharge
☐ Penile Lesion

NEUROLOGICAL SYSTEM

☐ Sense of Smell Changes
☐ Taste Disturbances
☐ Difficulty Keeping Balance
☐ Difficulty in Speech
☐ Abnormality of Walk
☐ Tingling
☐ Numbness
☐ Headaches
☐ Fainting
☐ Dizziness
☐ Confusion
☐ Memory Loss
☐ Vertigo

PSYCHIATRIC HISTORY

☐ Interpersonal Relationship Problems
☐ Sleep Disturbances
☐ Depression
☐ Anxiety
☐ Memory Lapses / Loss
☐ Hallucinations
☐ Thoughts of Hurting Yourself
☐ Thoughts of Hurting Someone Else
☐ Agitation
☐ Restless
☐ Sadness

Do you have a copy of your child's immunization record? ☐ Yes ☐ No

Please indicate date of vaccines if known and bring child's vaccine record to the 1st appointment and anytime a vaccine is given thereafter outside of our clinic.

HEBATITIS B (3)					
DTaP (5)					
HIB (4)					
PNEVNAR (4)					
ROTAVIRUS (3)					
POLIO (4)					
MMR (2)					
VARICELLA (2)				**Had Disease Date:**	
HEB A (2)					
MENINGOCOCCAL (1)					
GARDASIL (3)					
LAST INFLUENZA					
TDAP					