Midwest Immunology Clinic
Patient Medical History Form (PEDIATRIC)

Patients who have completed and returned this form will have priority if on our cancellation list.

Appointment Dates: _____

Patient Name: _____ **DOB:** _____ **Age:** _____

Mother's Name: _____ **Father's Name:** _____

PRIMARY CARE MD: _____

Location: _____ **Phone:** _____

REFERRING MD: _____

Location: _____ **Phone:** _____

Main reason for today's visit: _____

Current Pharmacy Name/Location: _____

MEDICAL HISTORY

Diagnosis	Date diagnosed	Care Provider	**Medications/Therapies for this diagnosis** (name/dosing/prescriber)

SURGICAL HISTORY

Date	Surgery	Provider/Hospital

HOSPITALIZATIONS (not including surgeries listed above)

Date	Reason	Provider/Hospital

OTHER MEDICATIONS (please include vitamins, herbal supplements, and over-the-counter medications)

Medication	Dosage	Prescribing MD/NP	Medication	Dosage	Prescribing MD/NP

ALLERGIES/REACTIONS (include medications, pollens, foods, latex, venom, or other products):

Medication/Product	Reaction	Medication/Product	Reaction

FAMILY HISTORY

Mother:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

Father:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

Brother/Sister:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

Brother/Sister:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

Brother/Sister:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

Brother/Sister:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

Brother/Sister:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

Brother/Sister:
Living - Yes; Age ____________
Living - No; Cause of death ______________________________ Age _____
Lifetime Diseases (if any) ______________________________

PERSONAL/FAMILY HISTORY

Has your child or have any close members in your family (**not listed above**) including your child's grandparents, aunts, and/or uncles had any of the following medical conditions?

( ) None/Unknown

	Self	Family	Relationship	Age Diagnosed
Allergies/Asthma	( )	( )		
Anxiety/Depression	( )	( )		
Bleeding/Clotting problems	( )	( )		
Bone/Joint Disease	( )	( )		
Bowel Disease (e.g. Colitis)	( )	( )		
Eczema/Atopic Dermatitis	( )	( )		
Heart Disease/Heart Attack	( )	( )		
Heartburn/Reflux	( )	( )		
High Blood Pressure	( )	( )		
Immune Deficiencies	( )	( )		
Leukemia/Lymphoma	( )	( )		
Lung Disease (e.g. COPD)	( )	( )		
Lupus	( )	( )		
Osteoporosis	( )	( )		
Other Cancers	( )	( )		
Recurrent Infections	( )	( )		
Skin Disease (e.g. Psoriasis)	( )	( )		
Stroke	( )	( )		
Thyroid Disease	( )	( )		
Tuberculosis	( )	( )		

CURRENT REVIEW OF SYMPTOMS - please circle if your child has experienced any of the following:

Cardiac: Fatigue Chest Pain Palpitations Swelling/Edema (location):_____

Endocrinologic: Cold/heat tolerance Excess urination Excessive thirst Hair growth Hair loss

General: Fatigue Fevers Night sweats Sun sensitivity Unexplained weight loss/gain

GI: Abdominal pain Black stool Blood in stool/on tissue Constipation Diarrhea Nausea

GU: Change in urine color Frequent urination Frequent urine infections Heavy menses Irregular menses Menopausal symptoms (hot flashes/night sweats) Painful urination

HEENT: Bleeding gums Ear Pain Eye/ear drainage Eye redness Hearing Loss Nasal congestion Nose/mouth ulcers Runny nose Sore throat Thrush Vision change (blurred/double)

Musculoskeletal: Bone pain Joint pain Joint redness Joint swelling Muscle pain Weakness

Neurologic: Headaches Numbness/tingling Seizures Weakness

Psychologic: Anxiety Depression Insomnia Memory loss

Respiratory: Cough Shortness of breath Sputum production Wheezing

Skin: Acne Dry skin Hives Poor wound healing Rash Swelling Warts

Other: Bruising Dental problems Neck stiffness Nosebleeds Swollen glands/nodes

SOCIAL HISTORY

With whom does your child primarily live:_____

Does your child live in multiple households:_____

Describe the household(s) where your child lives (e.g. house, apartment):_____

Are there any pets: Yes No If yes, list:_____

Are there problems with: Pests_____ Rodents_____ Water damage_____

Does your child attend daycare/school:_____

If yes, where/what grade:_____

Are you (or your child's parents/guardians) employed: Yes No

If yes, where/title:_____

Does your child have smoke exposure: Yes No

If yes, describe:_____

Does your child follow a special diet: Yes No If yes, what type:_____

Has your child received a blood transfusion: Yes No

If yes, date/circumstances:_____

Has your child traveled internationally: Yes No

If yes, when/where:_____

HEALTH MAINTENANCE

Date of last vision screening:_____ History of abnormal vision screen: Yes No

If yes, when/what was done:_____

Date of last pulmonary function test (PFTs):_____ History of abnormal PFTs: Yes No

If yes, when/what was done:_____

Date of last bone density (DEXA) scan:_____ History of abnormal DEXA scan: Yes No

If yes, when/what was done:_____

Has your child received a tuberculin (TB) skin test (eg, PPD/Mantoux): Yes No

If yes, date:_____ Result_____

Federal Race/Ethnicity Information

In compliance with Federal regulations,
Midwest Immunology Clinic collects information on race/ethnicity,
country of origin and primary language for all patients we serve.

Is your child of Hispanic, Latino or Spanish origin: Yes No

What is your child's race/ethnicity (circle one):

Mexican/Mexican-American/Chicano Puerto Rican Cuban
White/Caucasian Black/African-American American Indian/Alaskan Native
Asian Indian Chinese Filipino Japanese Korean Vietnamese
Hmong Native Hawaiian Guamanian/Chamorro Samoan Somali

Country of origin:_____ Primary Language:_____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____