Internal Medicine
of West Michigan

NEW Pediatric Patient History

IMWM

Child's Name (First, Last): ______________________________________ Birth Date: ____________

Mother's Name: ______________________________________
Father's Name: ______________________________________
Parent/Guardian Email Address: ______________________________________
Child lives with: ☐Parent ☐ Step-parent ☐ Grandparent ☐ Other: ____________________

BIRTH HISTORY

Delivery Method: ☐ Vaginal ☐ C-Section
Any problems before, during, or after child's delivery? ______________________________________

PERSONAL MEDICAL HISTORY

DISEASE / CONDITION	CURRENT	PAST	COMMENTS
Allergies			
Asthma			
Birth Defects			
Cancer (*type:*__________________)			
Depression /Anxiety/Insomnia			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney (*Renal*) Disease			
Migraines/Headaches			
Seizures			
Other:			
Other:			

OTHER SPECIALISTS: Does your child see any other healthcare providers? ☐ Yes ☐ No
If yes, please list: ______________________________________

MEDICATIONS

NAME, DOSE & FREQUENCY	

ALLERGIES (*Medication, food, or other*)

SURGERY / HOSPITALIZATIONS HISTORY

TYPE (*Specify Left / Right*)	DATE	LOCATION/FACILITY

GIRL'S HEALTH HISTORY

Age of First Period:	Date of last period:

BOY'S HEALTH HISTORY

Circumcision: ☐Yes ☐ No	

ADDITIONAL HEALTH HISTORY *(include date)*

Hemoglobin / Anemia screening:
Lead screening:
Autism screening:

SOCIAL HISTORY

School: Grade level:	Extracurricular Activities:
Smoke Exposure? YES / NO	

FAMILY MEDICAL HISTORY

DISEASE / CONDITION	FAMILY MEMBER / AGE / AGE AT DEATH
Alcoholism	
Asthma	
Cancer (*type:*__________________)	
COPD	
Depression /Anxiety/Insomnia	
Diabetes (*type:*________________)	
Heart Disease	
High Blood Pressure (*Hypertension*)	
High Cholesterol	
Kidney (*Renal*) Disease	
Migraines/Headaches	
Stroke	
Other:	
Other:	

IMMUNIZATIONS (*please attach copy of records)*

Patient Name (*please print)*:____

Parent/Guardian Signature: ____**Today's Date:** ________________

Physician Signature: ____Today's Date: ______________

Confidentiality of this medical record shall be maintained except when use of disclosure is required or permitted by law, or written by the patient/guardian.

Internal Medicine
of West Michigan
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