Door County Medical Center

Pediatric Medical History

Please complete the attached form and provide our staff with an accurate, up to date health history.
This information will be used to update your electronic medical record.
This tool will help us continue to provide excellent care to you and your family.

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Patient Name____**DOB**______________

Today's Date______________________________

Name of Provider you are seeing____

Personal Medical History: (please circle if your child has or has ever had)

Neurological:		
Parkinson's Disease	Seizure Disorder	Stroke
Mini-Stroke (TIA)	Dementia	Headaches
Multiple Sclerosis	Peripheral Neuropathy	Concussion
Cardiac:		
Coronary Artery Disease	Mitral Valve Prolapse	Heart Attack
Congestive Heart Failure	Atrial Fib	Hypertension
Hypercholesteremia	Peripheral Vascular Disease	Valvular Heart Disease
Enlarged Heart (Cardiomyopathy)		
Ear/Nose/Mouth/Throat:		
Cataracts	Macular Degeneration	Chronic Sinusitis
Glaucoma	Hearing Loss	Allergic Rhinitis
Retinopathy	Chronic Ear Infections	
Respiratory:		
Asthma	Chronic Obstructive Pulmonary Disorder	
Chronic Bronchitis	Pneumonia	Emphysema
Sleep Apnea		
Gastrointestinal:		
Crohn's Disease	Gastrointestinal Bleed	Pancreatitis
Peptic Ulcer	Ulcerative Colitis	Cirrhosis
Acid Reflux (GERD)	Diverticulitis	Hepatitis
Chronic Constipation	Irritable Bowel	Hemorrhoids
Chronic Diarrhea		
Urological:		
Recurrent Urinary Tract Infections	Chronic Renal Disease	End Stage Renal Disease
Kidney Stones	Benign Prostate Hypertrophy	Incontinence
Reproductive:		
Endometriosis	Abnormal PAP	Chlamydia
Fibroids	Pain during menstruation	Gonorrhea
Pelvic Inflammatory Disease	Syphilis	Menstrual Disorder
Sexually Transmitted Disease	Genital Herpes	Ovarian Cyst
Trichomonas	Genital Warts	
Musculoskeletal:		
Rheumatoid Arthritis	Fibromyalgia	Lyme Disease
Osteoarthritis	Chronic Back Pain	Osteoporosis
Gout		
Endocrine:		
Type I Diabetes	Gestational Diabetes	Thyroid Disease
Type II Diabetes		
Hematology:		
Anemia	Sickle Cell	Clotting Problems
Hemophilia		

Psychosocial:		
Bipolar Disorder	Anxiety	Post Traumatic Stress Disorder
Depression	Attention Deficit Disorder	Eating Disorder
Obstructive Compulsive Disorder	Attention Deficit Hyperactivity Disorder (ADHD)	
Cancer:		
Breast Cancer	Leukemia	Lymphoma
Prostate Cancer	Colon Cancer	Skin Cancer
Lung Cancer		
Infectious:		
Shingles	Herpes	HIV
Tuberculosis	Human Papilloma Virus (HPV)	
MRSA		

Family History:

Please add relation and check all conditions that apply.

Relation: **(ie: brother, sister, etc**	**Mother**	**Father**			
Age of family member:					
Bleeding disorder					
Breast Cancer					
Coronary Artery Disease					
Chronic Obstructive Pulmonary Disease (COPD)					
Clotting Disorders					
Colon Cancer					
Diabetes					
Hypertension					
Hyperlipidemia					
Myocardial Infarction					
Mental Health					
Ovarian Cancer					
Prostate Cancer					
Thyroid Problems					

Pediatric Social History:

Mother's First Name	Occupation
Father's First Name	Occupation
Siblings Names	
If separated/divorced, which parent has custody	Name
Child in DayCare	Yes No
Immunizations	Up to Date Delayed Non-immunized
Which School do you attend?	Algoma Gibralter Kewaunee Sevastopol Sturgeon Bay Southern Door Washington Island Other
School Concerns?	Explain
Sports you participate in	
Water Source	City Well Bottled
Fluoride Content	Yes No
Birth Information	Term Pre-term Vaginal delivery C-section Birth weight: lb oz

Surgical History

Has child had any surgeries? If so, list type: