

PMA: PAST MEDICAL, FAMILY AND SOCIAL HISTORY: AGE 5 YEARS AND OLDER

Date: _____

Name: _____

Patient's Past Medical History

Prior Testing	None	Yes	Test: _____
Allergies	No	Yes	
History of Chicken Pox	No	Yes	
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth, Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
Gastrointestinal Disorder	No	Yes	
Genito-urinary/Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric/Learning Disorder	No	Yes	
Skin Disease	No	Yes	
History of Injury/Trauma	No	Yes	Details: _____
Other Medical History	_____		

Family Medical History

Please list family member below

Bleeding Disorder	No	Yes	_____
Cancer	No	Yes	_____
Diabetes	No	Yes	_____
Cardiovascular Disorder	No	Yes	_____
Congenital Heart Disease	No	Yes	_____
Eye Disorder	No	Yes	_____
Ear Disorder	No	Yes	_____
Respiratory Disorder	No	Yes	_____
Gastrointestinal Disorder	No	Yes	_____
Musculoskeletal Disorder	No	Yes	_____
Neurologic Disorder	No	Yes	_____
Psychiatric Disorder	No	Yes	_____
SIDS	No	Yes	_____
Skin Disease	No	Yes	_____
Other remarkable family history	_____		

Surgical/Hospitalization History

Details:

Non-Surgical Hospitalizations	No	Yes	_____
Surgical History	No	Yes	_____
Ear Surgery	No	Yes	_____
Nose/Mouth/Throat Surgery	No	Yes	_____
Respiratory Surgery	No	Yes	_____
Cardiovascular Surgery	No	Yes	_____
Gastrointestinal Surgery	No	Yes	_____
Genito-urinary Surgery	No	Yes	_____
Eye Surgery	No	Yes	_____
Orthopedic Surgery	No	Yes	_____
Plastic Surgery	No	Yes	_____
Other Surgery	_____		

Child Social History

Parent Information:

(circle all that apply)

Parents together
Lives with mother
Lives with father
Guardian parents
Same sex partners

Father involved
Mother involved
Father not involved
Mother not involved
Mother/father deceased

Child Care:

Name of Daycare: _____
Home with parents
Private home daycare
Sitter to home
Family daycare
Other: _____

Yes No
Yes No
Yes No
Yes No

Home occupants (list all):

Parents smokers (circle one):

Yes No Outside only

Household Heating/AC type

Radiator Forced Hot Air Central/Room Gas Electric

Pets

#inside

Outside

None _____
Dog(s) _____
Cat(s) _____
Bird(s) _____
Reptile(s) _____
Rodent(s) _____
Fish _____

Primary Language in home:

English Spanish Korean Italian Other: _____

Extracurricular activities/hobbies:

Educational/School Information

Name of School: _____

Grade: _____

School performance:

Circle all that apply: Likes school Dislikes school Advanced Program Honor Roll
Excellent Good Fair Poor

School issues: None Behavior problems Peer Problems Non-attendance
Expelled Suspended Referred for ADHD Testing by school

Menstrual History (Female Only)

Approximate Last menstrual period _____ Menarche (Age) _____
Length of menstrual cycle _____ Amount of flow _____

Patient Smoking Status (13 years and over) Circle ONE

1. Current everyday smoker
2. Current someday smoker
3. Former smoker
4. Never smoked
5. Smoker, current status unknown
6. Unknown if ever smoked