MUNSON HEALTHCARE
Otsego Memorial Hospital

PEDIATRIC AND ADOLESCENT HEALTH HISTORY

PLEASE ANSWER THE QUESTIONS BELOW **Provider:**

Patient: _____ DOB: _____ Today's Date: _____

Type of Insurance:

PARENTS:

Mother	Father
Name:	Name:
DOB:	DOB:

Siblings

Name:	DOB:	MALE/FEMALE
Name:	DOB:	MALE/FEMALE
Name:	DOB:	MALE/FEMALE
Name:	DOB:	MALE/FEMALE
Name:	DOB:	MALE/FEMALE

PAST MEDICAL HISTORY

Has your child ever been in the hospital? Yes/No

If yes, please explain:

Is your child being treated for any illness? Yes/No

If yes, please explain:

Is your child up to date on Immunizations? Yes/No

Has your child had the chicken pox? Yes/No

MEDICATIONS

Is your child taking any medications at this time? Yes/No

Please list medications:

PAST SURGICAL HISTORY

Has your child ever had any surgery? Yes/No

If yes, please explain:

ALLERGIES

Does your child have any allergies to drugs?

Other allergies?

FAMILY HISTORY (MOTHER, FATHER, SIBLINGS)

Condition			Relationship	Condition			Relationship
Bleeding	Yes	No		Diabetes	Yes	No	
Tuberculosis	Yes	No		High Blood Pressure	Yes	No	
Heart Problems	Yes	No		Kidney Problems	Yes	No	
Mental Illness	Yes	No		Headaches	Yes	No	
Seizures	Yes	No		Other:			

SOCIAL HISTORY

Parents are: Together Divorced Separated Deceased

Name of Legal Guardian:

Who usually cares for the child:

Do you get assistance from a home health nurse, mental health agency, social services or hospice? Specify

Phone:

Phone:

Is there any other information we should know?