Pediatric TLC
Complete health care for tots and teens
P.C.

PATIENT HISTORY

Patient's Name ______________________ DOB ________ Age ________ ☐ Male ☐ Female

Form Completed By ______________________ Date Completed ________

Household

Please list all those living in the child's home:

Name ____________ Relationship to Child ____________ Health Problems ____________ DOB ________

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Name ____________ Relationship to Child ____________ Health Problems ____________ DOB ________

Are there siblings not listed? If so, please list their where they live, name, and ages.

Where They Live ____________ Name ____________ Age ________

Where They Live ____________ Name ____________ Age ________

Where They Live ____________ Name ____________ Age ________

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Lives with foster family ☐ Joint custody ☐ Single custody

If one or both parents are not living in the home, how ofter does the child see the parent(s) not in the home?

____

Fathers Employer ______________________ Phone ____________

Mothers Employer ______________________ Phone ____________

Current Medications ____

____

GENERAL

DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK

Explain ____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK

Explain ____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK

Surgery ______________________________ Date ________

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK

Reason ______________________________ Date ________

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK

Medication ____________________ Reaction ____________________

Medication ____________________ Reaction ____________________

Continued on next page

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PATIENT HISTORY

Past History
DK = don't know

Does your child have or has your child ever had:

Condition	Yes	No	DK	
Chickenpox	☐ Yes	☐ No	☐ DK	When ____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain ____
Problems with ears of hearing	☐ Yes	☐ No	☐ DK	Explain ____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain ____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain ____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain ____
Any heart problems or heart murmur	☐ Yes	☐ No	☐ DK	Explain ____
Anemia or bleeding problems	☐ Yes	☐ No	☐ DK	Explain ____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain ____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain ____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain ____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain ____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain ____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain ____
Bed wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain ____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain ____
Chronic or recurrent skin problems (eg. acne, eczema)	☐ Yes	☐ No	☐ DK	Explain ____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain ____
Seizures or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain ____
Obesity	☐ Yes	☐ No	☐ DK	Explain ____
Diabetes	☐ Yes	☐ No	☐ DK	Explain ____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain ____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain ____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain ____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain ____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain ____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain ____
Dental decay	☐ Yes	☐ No	☐ DK	Explain ____
History of family violence	☐ Yes	☐ No	☐ DK	Explain ____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain ____
Problems with periods (for girls)	☐ Yes	☐ No	☐ DK	Explain ____

Has had first period ☐ Yes ☐ No Age of first period ____

Any other significant problems

____

____