TRESTLEWOOD PEDIATRICS

Robert B. Page, M.D., F.A.A.P.
Stephanie Somers, M.D., F.A.A.P.
Anthony J. Van Es, M.D., F.A.A.P.
Rebekah Lampart, M.D., F.A.A.P.

Medical History Form

Child's Name _____ Birth date _____ Phone _____
Address _____ City/State/Zip _____
Gender ☐ M ☐ F _____ Ethnicity _____

Name	Address/Phone	Occupation/Employer
Parent 1 _____	_____	_____
Parent 2 _____	_____	_____
Guardian _____	_____	_____

Source of referral _____ Friends/relatives who come to the practice _____
Previous physician _____ When/from where did you move? _____

Child's Medical History

Allergies _____ Medications _____
Length of pregnancy in weeks _____ Pregnancy/delivery complications _____
Type of delivery: ☐ vaginal ☐ caesarean Apgar scores/birth condition _____
Birth weight _____ Infant diet: ☐ breast ☐ bottle How long? _____

Hospitalizations, Surgeries, Trauma, Injuries

Date	Type/Reason
_____	_____
_____	_____
_____	_____

Recurrent problems
- ☐ Otitis media
- ☐ Tonsillitis
- ☐ UTI
- ☐ Constipation
- ☐ Bedwetting

Other/Comment _____
_____

Chronic conditions
- ☐ Asthma
- ☐ Eczema
- ☐ Diabetes
- ☐ Seizures
- ☐ Congenital Heart Disease

Other/Comment _____
_____

Childhood Infections
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ RSV
- ☐ Rotavirus
- ☐ Pertussis
- ☐ Mono
- ☐ HIV
- ☐ Hepatitis
- ☐ Meningitis
- ☐ Measles/Mumps/Rubella
- ☐ UTI
- ☐ Pneumonia

Other/Comment _____
_____
_____
_____

Developmental/Behavioral/Psychiatric conditions
- ☐ Learning Problems
- ☐ Autism
- ☐ Speech Delay
- ☐ Eating Disorder
- ☐ ADD / ADHD
- ☐ Depression
- ☐ Oppositional Defiance Disorder

Other/Comment _____
_____
_____
_____
_____
_____
_____

TRESTLEWOOD PEDIATRICS, MEDICAL HISTORY FORM

Child's Environmental/Social History

Child lives with: (include siblings)	Name	Relationship	Age

Parents' relationship: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed

Other living arrangements: _____

Check all that apply:

☐ Older home/lead or peeling pain	☐ Fluoridated Water	☐ Parental tobacco use
☐ Bike Helmet	☐ Pets	☐ Car seat/Booster seat
☐ Pool/water near home	☐ No aspirin use	☐ Trampoline
☐ Working smoke detectors	☐ Exposure to TB	☐ Hot water temp <120F
☐ Infant walker with wheels		

Daycare (Group/private/#days per week) _____

School/grade/academic achievement _____

Sports/activities _____

Is this child adopted? ☐ Yes ☐ No Foreign or Domestic adoption? _____

Child's Family History

	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Cousin
Blood disorder (anemia, sickle cell, hemophilia, bleeding, etc.)	☐	☐	☐	☐	☐	☐
Lung condition (asthma, CF, etc.)	☐	☐	☐	☐	☐	☐
Cardiac problem (heart attack, arrhythmia, cholesterol, etc.)	☐	☐	☐	☐	☐	☐
Gastrointestinal problem (reflux, ulcers, Crohn's, colitis, etc.)	☐	☐	☐	☐	☐	☐
Neurological problems (seizures, MS, autism, etc.)	☐	☐	☐	☐	☐	☐
Psychiatric disorder	☐	☐	☐	☐	☐	☐
Vision or Hearing loss	☐	☐	☐	☐	☐	☐
Birth defect	☐	☐	☐	☐	☐	☐
Child or young adult death	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Behavioral or Learning problem	☐	☐	☐	☐	☐	☐
Substance Abuse problem	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Skin condition	☐	☐	☐	☐	☐	☐

Please provide more detail regarding any conditions noted above. Also include any other familial conditions not listed.

_____

_____

_____

5082 Lovers Lane • Portage, MI 49002 • Phone: 269-381-0118 • Fax: 269-381-4610 • www.trestlewoodpediatrics.com