The Pediatric Group, PC

Annual Medical History Update

Patient's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____

Signature: _____ Date Signed: _____

In the past year has the patient;

Been hospitalized? ☐ Yes ☐ No

If yes, when and what for? _____

Had surgery? ☐ Yes ☐ No

If yes, when and what for? _____

Suffered a serious injury? ☐ Yes ☐ No

If yes, when and what for? _____

Had a concussion? ☐ Yes ☐ No

If yes, when and what for? _____

Visited a specialist? ☐ Yes ☐ No

If yes, when and what for? _____

Developed a food allergy? ☐ Yes ☐ No

If yes, when and what for? _____

Visited a foreign country? ☐ Yes ☐ No

If yes, when and what for? _____

Update Family and Social History

Does Mom or Dad have high cholesterol?	☐ Yes	☐ No
Have there been any changes in who lives in the home? (divorce, separation, death in the family, etc)	☐ Yes	☐ No
Are there any smokers in the home?	☐ Yes	☐ No
Does the patient have any new medication?	☐ Yes	☐ No
Does the patient have any new allergies?	☐ Yes	☐ No
Does the patient have any new medication allergies?	☐ Yes	☐ No