Place Label Here

Pediatric Patient Reported Medical History

PERSONAL INFORMATION

Name: _____DOB: _____

Gender Assigned at Birth: ☐ M ☐ F Gender Association: _____

Parent's Name: _____Phone:_____

Primary Physician's Full Name: _____Phone: _____

LIFESTYLE

Covid-19 Infection in the last year? ☐ No ☐ Yes, if yes: _____ Date of most recent positive test.

RSV/Viral Infection in the last year? ☐ No ☐ Yes, if yes: _____ Date of most recent infection.

Influenza Infection in the last year ☐ No ☐ Yes, if yes: _____ Date of most recent infection.

History of Tick Bite? ☐ No ☐ Yes, if yes: _____ Date of most recent tick bite.

FAMILY HISTORY

Relationship	Illnesses	Age at Death Illnesses	Cause Of Death
Parent 1			
Parent 2			
Sibling 1			
Sibling 2			

MEDICATIONS

Oral/ Topical/ Inhaled Medications	Frequency	Strength /Dose	Method	Start Date	Stop Date
Example: Zyrtec	1 x/day	5mg	Pill, drops, spray	5/2001	7/2011-OR-C*

---------- *If you are currently taking the medication, please write "C" ----------

ALLERGIES

Medication/Product	Describe Reaction	Year	NCS

HOSPITALIZATIONS, SURGERIES & PROCEDURES

Description	Year	NCS	Description	Year	NCS
PET's (Ear Tubes)			Hernia Repair		
Tonsillectomy			Testicular/Penile		
Adenoidectomy			Other:		
Appendectomy					

GRAYED AREAS ARE FOR SITE STAFF USE ONLY

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----------If condition is continuing, please write "C"----------

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√ Check all that Apply				√ Check all that Apply			
GENERAL	Start Year	End Year	NCS	**MALES (REPRODUCTIVE/SEXUAL)**	Start Year	End Year	NCS
Allergies, Environmental				Hydrocele			
Insomnia				Testicular Torsion			
Tobacco Use				Undescended Testicle			
Vaping History				Other:			
Drug/Alcohol Use:							
				ENDOCRINE/METABOLIC	Start Year	End Year	NCS
EYES, EARS, NOSE, THROAT	Start Year	End Year	NCS	Diabetes			
Vision Loss / Glasses				Elevated Cholesterol			
Hearing Loss				Obesity			
Other:				Thyroid Disease/Nodule			
RESPIRATORY/CHEST	Start Year	End Year	NCS	**NEUROLOGICAL**	Start Year	End Year	NCS
Asthma				Seizure Disorder			
Obstructive Sleep Apnea				Headaches [Tension/Stress]			
Cystic Fibrosis				Migraine Headaches w/o Aura			
Other:				Migraine Headaches w/ Aura			
				Muscular Dystrophy			
CARDIOVASCULAR	Start Year	End Year	NCS	Other:			
Cardiac Defect							
Heart Murmur				**MENTAL HEALTH**	Start Year	End Year	NCS
Long QT Syndrome				Anxiety			
High Blood Pressure				Depression			
Other:				ADD/ADHD			
				MUSCULOSKELETAL/IMMUNE	Start Year	End Year	NCS
GASTROINTESTINAL	Start Year	End Year	NCS	Lyme Disease			
GERD [Acid Reflux/Heartburn]				Low Back Pain			
Irritable Bowel Syndrome				Rheumatoid Arthritis			
Crohn's/Ulcerative Colitis				IGG Deficiency			
Constipation				Fracture:			
Liver Disease							
Gilbert's Disease				**SKIN**	Start Year	End Year	NCS
				Acne			
URINARY/RENAL	Start Year	End Year	NCS	Eczema			
Kidney Stones				Cold Sores			
Hydronephrosis				Hives			
Urinary Reflux				Other:			
FEMALES (REPRODUCTIVE/SEXUAL)	Start Year	End Year	NCS	**BLOOD (HEMATOLOGIC)**	Start Year	End Year	NCS
Last Menstrual Period Date				Anemia			
Irregular Periods				Thalassemia			
UTI				Sickle Cell Trait			
Other:				Other:			

Study Participant's Signature:
(Upon Completion or updating of form, sign & date next available line)

Medical Provider's Signature:

Completed by: _____ Date: _____ Reviewed by: _____ Date: _____

Completed by: _____ Date: _____ Reviewed by: _____ Date: _____

Completed by: _____ Date: _____ Reviewed by: _____ Date: _____