Group Health Cooperative
of South Central Wisconsin

General Medical History Form: PEDIATRIC - Newborn through age 17

Please complete all sections that are APPROPRIATE FOR the current AGE of your child.

Name:		**Date:**	**GHC#:**	
Address:		**City:**	**State:**	**Zip Code:**
Hm Ph: ( )	**DOB:**	**Attends Daycare:** ☐No ☐Yes: Name:		

Child Lives With: ☐Mother ☐Father ☐Step Parent/Family ☐Other: ____________ ☐Siblings-ages:

Name of Parent/guardian(s): Home:(   ) Work:(   )

Name of Parent/guardian(s): Home:(   ) Work:(   )

Emergency Contact 1: Relation: Home:(   ) Work:(   )

Emergency Contact 2: Relation: Home:(   ) Work:(   )

Ethnic Group: ☐African American ☐American Indian/Eskimo ☐Asian/Pacific Islander ☐Caucasian ☐Hispanic/Latino ☐Multi-Racial

Language Preference: **Cultural Needs and Preferences:**

Child's Allergies (include date noted if known):

Child's Medications (include dose if known):

Health concerns to be addressed at appointment:

Child's Tobacco Use Status: ☐Current ☐Former ☐Never
Does anyone in the household use tobacco? ☐Yes ☐No Comments: ______________________
☐Cigarette packs/day:______ #Years:_______ Quit Date:________ Other types: ☐Pipe ☐Snuff ☐Cigar ☐Chew

Child's Alcohol use: ☐No ☐Yes oz/week:__________ Comment:

Child's Drug Use: ☐No ☐Yes times per week:_____ ☐IV use Comment:

Girls: Age of first menstrual period: _________________ Date of last menstrual period: ______________________

Child's Sexual Activity: Sexually Active: ☐Not Currently ☐Yes ☐No Partners: ☐Male ☐Female
Contraception Method: ☐Condom ☐Pill ☐Diaphragm ☐IUD ☐Surgical ☐Spermicide ☐Implant ☐Rhythm ☐Injection ☐Sponge ☐Insert ☐Abstinence ☐Other:

Child's Activities of Daily Living/Misc: ☐Check here if there has been no change in this area since form last completed
Blood Transfusion: .... ☐No ☐Yes Weight Concern: .... ☐No ☐Yes Caffeine Concern: .... ☐No ☐Yes Follows Special Diet: .... ☐No ☐Yes Occupational Exposure: .... ☐No ☐Yes Practices Back Care: .... ☐No ☐Yes Hobby Hazards: .... ☐No ☐Yes Exercises regularly: ...... ☐No ☐Yes Sleep Concern: .... ☐No ☐Yes Wears Helmet on Bike: . ☐No ☐Yes Stress Concern: .... ☐No ☐Yes Wears Seat Belt: .... ☐No ☐Yes

Child's Immunization Dates: ☐Check here if there has been no change in this area since form last completed
DPT/DTaP: ______________________________ Chicken Pox (or date of illness) ______________ Hib: ____________________________________ **Tetanus Booster:** _________________________ Polio: ___________________________________ Influenza: _______________________________
MMR: ___________________________________ Pneumovax_______________________________
Hepatitis B: ______________________________ Hepatitis A _______________________________ Prevnar: _________________________________ Other: __________________________________

OVER PLEASE

☐**Check here if there has been no change on this page since form was last completed**

Child's Long-Term/Chronic Medical Concerns

Illness	Date of Diagnosis

Child's Surgery History

Surgical Procedure	Date of Surgery

Is the child adopted? ☐ Yes ☐ No **Family history unknown** ☐ Yes

Relation-ship	Coronary heart disease	Premature coronary heart disease	Congenital heart disease	Hyperlipidemia	Diabetes	Depression	Mental health problem	Hypertension	Stroke	Breast cancer	Colon cancer	Prostate cancer	Cancer	Alcoholism	Asthma	Allergies	Migraine	Obesity	Anesthesia	Genetic	Multiple sclerosis	Osteoporosis	Thyroid	Tuberculosis	HIV/AIDS	Epilepsy	Other
Mother																											
Father																											
Sister																											
Brother																											
Daughter																											
Son																											
MAunt																											
MUncle																											
PAunt																											
PUncle																											
MGMo																											
MGFa																											
PGMo																											
PGFa																											
Other																											

If Other, specify ____

Family History	**Alive**	**Name**	**Age at Death** (if deceased)	**Cause of Death** (if deceased)
Mother				
Father				
Circle One:				
Sibling M F				
Sibling M F				
Sibling M F				
Sibling M F				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Circle One:				
Child M F				
Child M F				
Child M F				
Spouse/Other M F				

Child's Birth History

Birth Length ________

Birth Weight ________

Birth Head Circumference ________

Discharge Weight ________

Gestational Age _______

Cesarean Section ☐ yes ☐ no

Apgars:

1 minute___________

5 minutes__________

10 minutes_________

Primary Nourishment

☐ unknown

☐ bottle-fed

☐ breast-fed Comments: