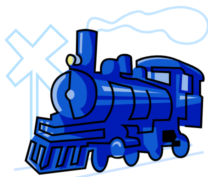

Wee Care Pediatrics
1440 S. Country Club Dr. Suite 21 Mesa, AZ 85210
Phone: 480-890-2273 Fax: 480-890-2201

Medical History

Today's Date: ___________

Name of the Patient _____________________________________Date of Birth: ____________________

Name of person completing this form ____

Patient Sex: M F Social Security # __________-__________-________________

How many people live with this patient? Adult's ___________ Children ________

Patient's Birth History: Birth weight _______________ Length ______________

During the pregnancy did the patient's mother:

Have any medical problems or complications? Yes No

If yes, please explain: ____

Smoke tobacco? Yes No

Drink alcohol? Yes No

Used any drugs or medications? Yes No

If yes, please explain: ____

Have any problems with labor or delivery? Yes No

If yes, please explain ____

Was the delivery: Vaginal Cesarean

Patient past Medical History

Overall health is: Good Fair Poor

Allergies to any medication? Yes No If yes, which medication ______________________________

What happens? ____

Currently taking any medications? Yes No

If yes, which medication? ____

Smoke tobacco? Yes No

Drink alcohol? Yes No

Use any drugs? Yes No

If yes, please explain: ____

Has the patient ever had any problems with any of the following? If yes, please explain.

Eyes/Vision	Yes	No	___________________________
Ears/Nose/Throat	Yes	No	___________________________
Headaches	Yes	No	___________________________
Joints/Bones	Yes	No	___________________________
Seizures	Yes	No	___________________________
Repeated Infections	Yes	No	___________________________
Heart/Lungs	Yes	No	___________________________
Stomach/Liver	Yes	No	___________________________
Intestines/Colon	Yes	No	___________________________
Kidneys/Urine	Yes	No	___________________________
Indigestion/Nutrition	Yes	No	___________________________
Anemia/Bleeding	Yes	No	___________________________

Patient past Medical History Continued:

Scan: Medinotes\Patient View\Multimedia\PMH: (Type in: PMH)

Please list any surgeries, hospitalizations, serious illnesses or accidents with dates:

________________________________ Date _________ _________________________ Date _________

_______________________________ Date _________ _________________________ Date _________
_______________________________ Date _________ _________________________ Date _________

Do you, as a parent, have any concerns about any of the following? If yes, please explain.
Growth/Development? Yes No ____
Behavior? Yes No ____
Eating habits? Yes No ____
Sleeping habits? Yes No ____
School? Yes No ____
Bathroom/Toilet? Yes No ____
Discipline? Yes No ____
Other? Yes No ____
Are Immunizations up to date? Yes No

Female Patients Only:
Are you having menstrual cycles? Yes No
At what age did menstruation began? ___________
Menstrual Period last Date? _____________
Are you cycle regular? ________________________
How many pregnancies? ____________
Number of births? ___________
Number of Living children? _______________
Last pap? ____________
Use birth control? Yes No
Name of Birth control? _________________

Patient's Family Medical History

Does any family member have any of the following medical conditions? If yes, please explain and state the relation with the patient (uncle, cousin, maternal grandfather, etc.)
Heart disease Yes No ____
Tuberculosis Yes No ____
High blood pressure Yes No ____
Kidney disease Yes No ____
Allergies/Asthma Yes No ____
Cancer Yes No ____
Bleeding disorder Yes No ____
Diabetes Yes No ____
Psychiatric problems Yes No ____
Seizures Yes No ____
Rheumatic fever Yes No ____
Genetic disorder Yes No ____
Thyroid disease Yes No ____
Lung disease Yes No ____
Bone/Joints Yes No ____
Other ____
To the best of my knowledge all the information provided is accurate and true.

____ Date: __________________
(Signature of person completing form)

Reviewed by: ____________

Scan: Medinotes\Patient View\Multimedia\PMH: (Type in: PMH)