- **IEP / 504 Plan:** ☐ No ☐ Yes
- **Concerns:** _____

Immunization History

- **Immunizations up to date:** ☐ Yes ☐ No ☐ Unsure
- **Exemptions / Delays / Notes:** _____

Current Medications

Medication Name	Dose	Frequency	Reason

Additional Medical Information

Please list any other medical conditions, concerns, or relevant history:

_____

_____

_____

Parent / Guardian Signature

- **Name:** _____
- **Signature:** _____ **Date:** _____

Significant Illnesses or Injuries

(Check all that apply)

☐ Recurrent ear infections

☐ Pneumonia / Bronchiolitis

☐ RSV

☐ COVID-19

☐ Concussions / Head injuries

☐ Fractures / Orthopedic injuries

☐ Serious infections (meningitis, sepsis): _____

☐ Other significant illness/injury: _____

Birth & Neonatal History (if applicable)

- **Gestational age at birth:** _____ weeks
- **Delivery type:** ☐ Vaginal ☐ C-section ☐ Assisted
- **Birth weight:** _____
- **Pregnancy complications:** ☐ No ☐ Yes (describe): _____
- **Newborn complications:** ☐ No ☐ Yes (describe): _____
- **NICU stay:** ☐ No ☐ Yes (length): _____

Developmental History

- **Developmental milestones:** ☐ On time ☐ Delayed ☐ Advanced
- **Therapies received:** ☐ None ☐ PT ☐ OT ☐ Speech ☐ Other: _____

☐ Heart Condition / Murmur (specify): _____

☐ Genetic or Congenital Disorder (specify): _____

☐ Developmental Delay / Autism / Learning Disorder

☐ ADHD / Behavioral Concerns

☐ Anxiety / Depression / Mood Concerns

☐ Gastrointestinal Condition (GERD, constipation, IBD, etc.): _____

☐ Kidney or Urinary Condition: _____

☐ Blood Disorder (anemia, sickle cell, etc.): _____

☐ Endocrine Disorder (thyroid, growth, etc.): _____

☐ Other (specify): _____

Hospitalizations

- ☐ None
- ☐ Yes (list reason(s), age(s), and date(s)):

_____

Surgical & Procedural History

- ☐ None
- ☐ Yes (include procedure and age/date):

_____

_____

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GROWING WITH YOU

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Pediatric Past Medical History (PMH) Form

Patient Information

- **Patient Name:** _____
- **Date of Birth:** _____ **Age:** _____ **Sex:** ☐ M ☐ F ☐ Other
- **Medical Record #:** _____
- **Date Completed:** _____
- **Completed by:** ☐ Parent ☐ Guardian ☐ Patient ☐ Other: _____

Chronic Medical Conditions

(Check all that apply)

☐ Asthma / Reactive Airway Disease

☐ Allergic Rhinitis / Seasonal Allergies

☐ Eczema / Atopic Dermatitis

☐ Food Allergies (specify): _____

☐ Medication Allergies (specify): _____

☐ Diabetes ☐ Type 1 ☐ Type 2

☐ Seizure Disorder / Epilepsy