Medical History Review

Framingham Pediatrics
Boston Children's
Primary Care Alliance

framinghampediatrics.com
508-879-5764

Today's date: ____

Patient name: ____

Date of birth: ____

Your pediatrician

❍ Dr. Baumel ❍ Dr. Crawford ❍ Dr. Garber
❍ Dr. Hicks ❍ Dr. Rosselot ❍ Dr. Whitman

Past medical history

(ex., at birth, major illnesses, hospitalizations, surgeries)

____

Date: ____

____

Date: ____

____

Date: ____

____

Date: ____

Current medical problems or new concerns

____

____

____

____

____

Current medications

List the medication, form (ex., liquid, chewable, pill), dosage and frequency.

Medication	Form	Dosage	Frequency
__________________________	_______	________	_______
__________________________	_______	________	_______
__________________________	_______	________	_______
__________________________	_______	________	_______
__________________________	_______	________	_______

Allergies

Allergen 1: __________________ ❍ Medication ❍ Food ❍ Other

Reproduction:

Reaction: ____

Allergen 2: _________________ ❍ Medication ❍ Food ❍ Other

Reaction: ____

Allergen 3: _________________ ❍ Medication ❍ Food ❍ Other

Reaction: ____

Family health history

Mother: ____

____

____

Father: ____

____

____

Sibling 1 name: _________________________________ Age: __

Major problems: ____

Sibling 2 name: _________________________________ Age: __

Major problems: ____

Sibling 3 name: _________________________________ Age: __

Major problems: ____

Is there a family history of:

Heart attack, stroke or high cholesterol before age 60? ❍ Yes ❍ No

Relation to patient: ______________________ Age of onset: ___

Sudden or unexplained death? ❍ Yes ❍ No

Relation to patient: ______________________ Age of onset: ___

Chest pain or heart symptoms related to exercise or exertion? ❍ Yes ❍ No

Relation to patient: ______________________ Age of onset: ___

Obesity or weight problems? ❍ Yes ❍ No

Relation to patient: ______________________ Age of onset: ___

Is there any family history of diabetes? ❍ Yes ❍ No

Other? ____