



Mesa Pediatrics
Professional Association

MPPA Health History

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: Female Male

A. Child's Birth History

Illnesses during pregnancy? Y N _____

Medications taken during pregnancy? Y N _____

Group B strep positive? Y N

Antibiotics during delivery? Y N If yes, number of doses: _____

Where was your baby born? _____

Referring OB/Doctor? _____

Baby's gestational age: _____ weeks _____ days

Delivery: Vaginal C-Section - Reason for C-Section _____

Birth Weight: _____ lbs _____ oz Birth Length: _____ inches

Age at discharge from hospital: _____

Complications during hospitalization: Y N _____

Was your baby:

Jaundiced: Y N how long? _____

Breast fed: Y N how long? _____

Formula fed: Y N how long? _____

Which formula? _____

Did your baby receive:

Vitamin K shot? Y N Erythromycin eye ointment? Y N

Hepatitis B vaccine in the hospital? Y N

If yes, date vaccine received: _____

Pass the hearing screen? Y N

B. Child's Past Medical History

1. Hospitalizations/Major Illnesses or Major Injuries/Surgeries

Year	Major Illness/Injury/Surgery	Hospital if required

Does your child have allergic reactions to: Medicines Y N

Foods: Y N Other: Y N Describe: _____

Does your child take any daily or seasonal medications? Y N ?

Describe: _____

Are your child's vaccinations up to date? Y N ?

2. Illnesses

Has your child ever had the following?

- Abdominal pain..... Y N ?
- ADHD..... Y N ?
- Allergic rhinitis..... Y N ?
- Allergies..... Y N ?
- Anemia..... Y N ?
- Asthma / wheezing..... Y N ?
- Autism..... Y N ?
- Bleeding disorder..... Y N ?
- Blood transfusions..... Y N ?
- Chickenpox..... Y N ?
- Congenital deformity..... Y N ?
- Congenital heart disease..... Y N ?
- Constipation..... Y N ?
- Cystic fibrosis..... Y N ?
- Developmental delay..... Y N ?
- Diabetes mellitus..... Y N ?
- Eczema..... Y N ?
- Epilepsy..... Y N ?
- Failure to thrive..... Y N ?
- Febrile seizures..... Y N ?
- Headache..... Y N ?
- Hearing problems..... Y N ?
- Heart murmur..... Y N ?
- Hepatitis..... Y N ?
- Hyperthyroidism..... Y N ?
- Hypothyroidism..... Y N ?
- Jaundice - history of..... Y N ?
- Learning problem..... Y N ?
- Migraine..... Y N ?
- Pneumonia..... Y N ?
- Prematurity - history of..... Y N ?
- Recurrent ear infections..... Y N ?
- Seizures / epilepsy..... Y N ?
- Speech delay..... Y N ?
- Vision problems..... Y N ?
- Whooping cough..... Y N ?

C. Developmental History

Milestones	Age Achieved	Milestones	Age Achieved
Rolled Over		Walked	
Sat alone		Spoke first words	
Crawled		Used sentences	
Stood alone		Toilet trained	

Health History Continued

Patient Name: _____

Date of Birth: _____

D. Family History

Relation	Age	Health Condition
Father		
Mother		
Brothers		
Sisters		

Have any of your child's blood relatives had any of the following conditions?

Medical Condition		Relation to child
AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Arthritis, gout	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Birth defects	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Bleeding disorders	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Cystic fibrosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Epilepsy / seizures	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Mental Illness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Muscular dystrophy	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Obesity	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	
Other	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	

E. Social History

Are there any cigarette smokers in the home?	<input type="checkbox"/> Y <input type="checkbox"/> N	
Are there any pets in the home?	<input type="checkbox"/> Y <input type="checkbox"/> N	Please list: _____ _____
How many people live in the home?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8	Please list: _____ _____ _____
Does your child attend daycare?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe: _____ _____
Preschool?	<input type="checkbox"/> Y <input type="checkbox"/> N	
School?	<input type="checkbox"/> Y <input type="checkbox"/> N	Grade Level: _____

F. Additional Information

Signature: _____

Relation to patient: _____

Reviewed by / date: _____



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MPPA REVIEW OF SYSTEMS

Date _____

Patient Name: _____

Date of birth: _____

Please review the following list and check those that your child has complained about or suffered from in the past year. Mark **Y** if your child has experienced a problem, **N** if not. Depending on the age of your child some of these questions may not apply. If so, please mark **NA**.

- Discharge from vagina or penis Y N N
- Frequent urination Y N N
- Painful urination Y N N
- Bed-wetting problems Y N N

GENERAL

- Chills Y N N
- Fever Y N N
- Persistently Tired Y N N
- Sweats Y N N
- Loss of Weight Y N N

SKIN

- Acne Y N N
- Eczema Y N N
- Slow healing bruises Y N N
- Changing mole Y N N
- Excessive sweating Y N N
- Hives Y N N
- Persistent rashes Y N N

HEAD, EYE, EAR, NOSE, THROAT

- Vision problems Y N N
- Excessive tearing Y N N
- Loss of hearing Y N N
- Ear discharge Y N N
- Frequent ear infections Y N N
- Earache Y N N
- Frequent nosebleeds Y N N
- Nasal congestion Y N N
- Mouth breathing Y N N
- Snoring Y N N
- Allergies Y N N
- Sinus problems Y N N
- Bleeding gums Y N N
- Hoarseness Y N N
- Sores in mouth/gums Y N N
- Dental problems Y N N
- Been to dentist Y N N

- Frequent tonsil infections Y N N
- Difficulty talking Y N N
- Stuttering Y N N

RESPIRATORY

- Night-time cough Y N N
- Recurrent/chronic cough Y N N
- Shortness of breath Y N N
- Unable to keep up with peers Y N N
- Difficulty breathing Y N N
- Wheezing Y N N

CARDIOVASCULAR

- Chest pain Y N N
- Heart murmur Y N N
- Irregular heart beat Y N N
- Hypertension Y N N
- Difficulty breathing lying down Y N N

GASTROINTESTINAL

- Food restriction/dieting Y N N
- Stomach aches Y N N
- Dark stools Y N N
- Bloody stools Y N N
- Constipation Y N N
- Diarrhea Y N N
- Nausea Y N N
- Vomiting Y N N

GENITOURINARY

- Unusual urine odor Y N N
- Blood in urine Y N N

MUSCULOSKELETAL

- Prior fracture Y N N
- Scoliosis Y N N
- Back Pain Y N N
- Painful joints Y N N
- Swollen joints Y N N

NERVOUS SYSTEM

- Speech / gait problems Y N N
- Dizzy Y N N
- Fainting spells Y N N
- Headaches Y N N
- Seizures Y N N
- Tremors Y N N
- Weakness Y N N

PSYCHIATRIC

- Anxiety Y N N
- Change in sleep pattern Y N N
- Depression Y N N
- Inability to concentrate Y N N

ENDOCRINE

- Appetite change Y N N
- Cold intolerance Y N N
- Excessive thirst Y N N
- Excessive urination Y N N
- Heat intolerance Y N N

HEMATOLOGIC

- Abnormal bleeding Y N N
- Easy bruising Y N N
- Nose bleeds Y N N

Reviewed by / Date _____



Mesa Pediatrics
Professional Association

Mesa Pediatrics Vaccine Refusal Policy

Date: _____

Patient Name: _____ D.O.B.: _____

Mesa Pediatrics remains committed to the continuing pursuit of excellence in pediatric medicine, which includes preventive care. Our providers strongly believe in the use of childhood vaccinations to prevent serious medical diseases and in some cases, even death. We also believe in the safety of all of our patients, which at times includes young infants who are not yet eligible to receive these important vaccines.

For these reasons, starting June 1st, 2015, Mesa Pediatrics will no longer be accepting new patients who choose to defer all vaccinations for their children.

If you have questions regarding this policy, please do not hesitate to ask your provider.

I have read and understand Mesa Pediatrics Vaccine Refusal Policy. I am the parent of said minor child, or the court appointed guardian for the patient, and am authorized to act on the patient's behalf.

Parent / Guardian Signature

Print Name