

Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

PERSON COMPLETING FORM/RELATIONSHIP _____

DATE OF FORM COMPLETION _____

MEDICATIONS:

Medication	Dose	How many times a day
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALLERGIES: No Yes

If yes, to what medication(s) and what was the reaction _____

IMMUNIZATION HISTORY:

To the best of my knowledge, my child is up to date on his/her immunizations No Yes

If no, why? _____

BIRTH HISTORY:

Please indicate any medical problems during pregnancy _____

Please list any medications taken during the pregnancy _____

Any drug or alcohol use during the pregnancy No Yes _____

Delivered by elective C-section emergent C-section forceps vacuum extraction
 normal vaginal delivery

If not a normal vaginal delivery, why? _____

Number of weeks gestation _____

Birth weight _____ APGAR scores: 1 minute _____ 5 minute _____ Discharge weight _____

Did the baby receive the Hepatitis B vaccine No Yes If yes, date given _____

Please indicate any medical problems during the newborn period _____

Name of hospital where infant was born _____

PERSONAL MEDICAL HISTORY:

Please check if your child has had any of the following medical problems:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver disease/Hepatitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Concussion | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Fracture | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Vesicoureteral reflux |
| <input type="checkbox"/> Bronchiolitis | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Vision problems |

HOSPITALIZATIONS:

Has your child ever stayed overnight in a hospital? No Yes

If yes, when and why? _____

SURGICAL HISTORY:

Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

GYN HISTORY:

Age of first period _____ years First day of last period _____ Has not had menses yet _____

FAMILY HISTORY:

Please indicate if your child has a family history (**parents, siblings, grandparents, aunts, uncles or cousins to the child**) of any of the following:

Diagnosis	Family Member	Diagnosis	Family Member
<input type="checkbox"/> ADD/ADHD	_____	<input type="checkbox"/> Hearing disability	_____
<input type="checkbox"/> Alcohol/Drug Abuse	_____	<input type="checkbox"/> High cholesterol	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> HIV/AIDS	_____
<input type="checkbox"/> Birth defects	_____	<input type="checkbox"/> Learning disability	_____
<input type="checkbox"/> Blood disorders	_____	<input type="checkbox"/> Mental illness	_____
<input type="checkbox"/> Cancer, type	_____	<input type="checkbox"/> Mental retardation	_____
<input type="checkbox"/> Heart disease (heart attack, bypass, stents)	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Deafness/Hearing problems	_____	<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Seizure disorder	_____
<input type="checkbox"/> Developmental delay	_____	<input type="checkbox"/> Speech problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> TB/Lung disease	_____
<input type="checkbox"/> Genetic disorder	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Hepatitis/Liver disease	_____	<input type="checkbox"/> Thyroid disease	_____
		<input type="checkbox"/> Other	_____

SOCIAL HISTORY:

Who lives at home?

Name	Relationship	DOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the child cared for by any one other than the parents? No Yes

If yes, by whom and how frequently? _____

Does anyone in your home smoke? No Yes

Reviewed by Medical Provider _____ Date _____