Pediatric Medical and Family History Form

Patient's Name_____

Date of Birth: _____ Today's Date: _____

Parent's/Guardian's Name: _____

Sibling's: _____

Allergic Reactions to Medications, food, or vaccines:

_____

_____

Medications the patient is currently taking (please include both prescriptions and over the counter):

_____

_____

Delivery and Birth History

How was the patient delivered?

___Vaginal ___C-Section ____Adoption _____ Other

If known, how old was the mother at the time of delivery? _____

What was the baby's weight? _____ Hospital: _____

Did the patient pass the hearing screen? _____ yes _____no

Was the patient breech/feet first? _____ yes _____no

Was the patient premature? _____yes _____no How many months? _____

Please indicate any medical problems during the baby's newborn period:

_____

_____

Past Medical History

Has the patient ever been hospitalized? _____yes _____no

If yes, when and for what? _____

Has the patient ever had surgery? _____yes _____no

If yes, when and for what? _____

Has the patient ever had a serious injury? _____yes _____no

If yes, when and for what? _____

____ ADD/ADHD
____ Allergies
____ Anemia
____ Asthma
____ Autism
____ Broken Bones
____ Chicken Pox
____ Concussions
____ Constipation
____ Depression
____ Diabetes
____ Diarrhea
____ Ear Infections
____ Eczema
____ Food Allergies
____ Hearing Loss
____ Heart Disease
____ Heart Murmur
____ Rashes
____ Reflux
____ Seizures
____ Sickle Cell
____ Urinary Problems
____ Vaccine Reactions
____ Wheezing
____ Other Issues

Please briefly discuss any other issues or concerns about your child's health below

_____

_____

_____

Social History

Who does the patient live with? _____

Are Parents _____Married _____Unmarried _____ Separated ____ Divorced

If not married, custody status: _____

Please Circle: Apartment/Townhouse/House Age of Home? _____years

Do you have access to a pool? ____ yes ____ no

Are there any guns in the house? ____ yes ____ no

Are there any pets in the house? ____ yes ____ no If yes, what? _____

Any foreign travel within the past 5 years? ____ yes ____ no

If yes, where? _____

Are there any smokers in the home? ____ yes ____ no

If so, where do they smoke? ____ inside _____ outside

Water source: City Water or Well Water

Safety Seat (please circle): Rear facing/Forward facing 5 point harness/Booster/Seat Belt

Family History

Please state which of the following relatives have the conditions below (if none leave blank):

For grandparent/aunt/uncle please also put M for maternal family or P for paternal family

M=Mother F=Father GM=Grandmother GF=Grandfather B=Brother S=Sister A=Aunt

U=Uncle C=Cousin

____ ADD/ADHD	_____ Diabetes	____ Mental Illness
____ Alcoholism/Drug Abuse	_____ Diarrhea	____ Migraine/Headaches
____ Allergies	_____ Ear Infections	____ Rashes
____ Anemia	_____ Early Death	____Reflux
____ Asthma	_____ Eczema	____ Seizures
____ Autism	_____ Epilepsy	____ Sickle Cell
____ Autoimmune Disorder	_____ GI Disease	____ SIDS (sudden infant death syndrome)
____ Birth Defects	_____ Hearing Loss	____ Stoke before 55
____ Blood Disorders	_____ Heart Murmur	____ Thyroid Disease
____ Cancer	_____ High Blood Pressure	____ Tuberculosis
____ Constipation	_____ High Cholesterol	____ Urinary Problems
____ Cystic Fibrosis	_____ Kidney Disease	____ Vision Problems
____ Depression	_____ Liver Disease	

Other: _____

_____