Pediatric Medical and Family History Form

Patient's Name _____

Date of Birth: _____ Today's Date: _____

Parent/Guardian's Name: _____

Siblings: _____

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

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 home? ____ Yes ____ No

Are there any pets in the home? ____ 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 pt harness/Booster/Seatbelt

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	____Stroke 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:

_____

_____

_____

_____