Agave Family
Physicians, PLLC

Pediatric Medical History

Patient Name : ________________ Date Of Birth : ________________ Sex : ☐ M ☐ F

Mother's Name : ________________ Father's Name : ________________

BIRTH HISTORY :

Problems during pregnancy? ☐ no ☐ yes ________________

Medications taken during pregnancy? ________________

When was the child born? ☐ preterm (<37 weeks) ☐ term (37-42 weeks) ☐ post term (>42 weeks)

Where was the child born? ________________

How was the child born? ☐ Vaginal ☐ C-Section

What was the child's birth weight? ____________ length? ____________

How many days did the child stay in the hospital? ____________

Where there any complications? ? ☐ no ☐ yes ________________

Was / Is your child breast fed? ☐ no ☐ yes

MEDICAL HISTORY : (Check all that apply)

☐ ADHD	☐ Diabetes	☐ High Blood Pressure
☐ Allergies	☐ Digestive Problem ____________	☐ Mental Illness
☐ Anemia	☐ Eating Disorder	☐ Obesity
☐ Arthritis	☐ Ear Infections	☐ Seizure Disorder
☐ Asthma	☐ Eczema	☐ Speech Problem
☐ Birth Defects	☐ Hearing Loss	☐ Visual Impairment
☐ Bleeding Problems	☐ Heart Disease	☐ ____________
☐ Chicken Pox	☐ Heart Murmur	☐ ____________

MEDICATIONS :	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

MEDICATION ALLERGIES : ☐ no medication allergies

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MAJOR ILLNESSES / HOSPITALIZATIONS / SURGERIES :

Event ________________ Year _______ Event ________________ Year _______

Event ________________ Year _______ Event ________________ Year _______

FAMILY HISTORY :

Mother	☐ alive (age ____)	☐ deceased (age____)	Conditions ________________
Father	☐ alive (age ____)	☐ deceased (age____)	Conditions ________________
Sister	☐ alive (age ____)	☐ deceased (age____)	Conditions ________________
Brother	☐ alive (age ____)	☐ deceased (age____)	Conditions ________________
____________	☐ alive (age ____)	☐ deceased (age____)	Conditions ________________
____________	☐ alive (age ____)	☐ deceased (age____)	Conditions ________________

SOCIAL HISTORY :

Does the child use a carseat / toddler seat / seat belt? ☐ no ☐ yes

With whom does the child live? ________________

Are there any guns in the home? ☐ no ☐ yes

Are there any pets in the home (list type)?________________

Are there any smokers in the home? ________________

Does the child attend daycare? ____________ school? ____________ grade in school? ____________

Signature : ________________ Relation To Patient ____________Date : ____________

10-06 (8/07)