



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? _____

Were there any complications? no yes _____

Was / Is your child breast fed? no yes

MEDICAL HISTORY : (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Problem _____ | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Speech Problem |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> _____ |

MEDICATIONS :	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATION ALLERGIES : no medication allergies

MAJOR ILLNESSES / HOSPITALIZATIONS / SURGERIES :

Event _____	Year _____	Event _____	Year _____
Event _____	Year _____	Event _____	Year _____

FAMILY HISTORY :

Mother	<input type="checkbox"/> alive (age ____)	<input type="checkbox"/> deceased (age ____)	Conditions _____
Father	<input type="checkbox"/> alive (age ____)	<input type="checkbox"/> deceased (age ____)	Conditions _____
Sister	<input type="checkbox"/> alive (age ____)	<input type="checkbox"/> deceased (age ____)	Conditions _____
Brother	<input type="checkbox"/> alive (age ____)	<input type="checkbox"/> deceased (age ____)	Conditions _____
_____	<input type="checkbox"/> alive (age ____)	<input type="checkbox"/> deceased (age ____)	Conditions _____
_____	<input type="checkbox"/> alive (age ____)	<input type="checkbox"/> 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 : _____