Pediatric Health History Form

CHILD'S NAME: ________________________________DATE OF BIRTH: _____________
PREVIOUS PRIMARY CARE PROVIDER: ____
CHRONIC HEALTH CONCERNS: ____
HOSPITAZATIONS OR SURGERIES:____
CURRENT MEDICATIONS/VITAMINS:____
ALLERGIES/REACTIONS TO MEDICINES, VACCINES OR FOODS __________________
____

PARENT OCCUPATION: MOTHER __________________FATHER_________________________

PREGNANCY & BIRTH (this section for children under age 3 yrs.)

Is this child yours by: ___birth ___adoption _____stepchild _____ other ___________________________
Medical problems during pregnancy: ____
____
#of weeks pregnant _________ Birth weight: _________ Delivery by: __vaginal __caesarian
Medical problems during baby's newborn period: ____________________________________
____

SOCIAL HISTORY

daycare:_____________or current grade level ________other child care situation __________________
Who lives at home?

Name	Age	Relationship to Patient
________________________	______	____________________________
________________________	______	____________________________
________________________	______	____________________________
________________________	______	____________________________

Does anyone in the house smoke?___ (N) __(Y) if yes _______indoors ______outdoors
Are the child's parents: ____ married ___ unmarried ___separated ___ divorced

MEDICAL HISTORY FOR CHILD'S PARENTS AND CHILD'S BROTHERS AND SISTERS ONLY:
Please circle all that apply and indicate who has/had the condition:

ADD/ADHD	______	Hepatitis B or C	______
Alcoholism/drug abuse	______	High blood pressure	______
Asthma/hayfever/eczema	______	Inherited/genetic diseases	______
Birth Defects	______	Kidney disease	______
Bleeding/Clotting problem	______	Migraines	______
Cancer	______	Psychiatric disorders	______
Diabetes	______	Seizures	______
Fibromyalgia	______	Thyroid disease	______
Heart Disease	______	Other	______

Anything you think would be important for us to know regarding the care of your child that has not been mentioned in this form. ____
____
____