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

_____
_____

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 : _____