



## 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)

- |  |  |  |
|--|--|--|
| <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 : \_\_\_\_\_