PEDIATRIC MEDICAL HISTORY
Please answer the questions below for your child

Child's Name:		Date of Birth:
Hospitalizations? None Yes-list:		
Surgeries? None Yes-list:		
Any allergies? No Yes-list		
Any chronic illnesses? No Yes If yes, list:		
Has your child had chicken pox? No Yes If yes, when:		
Any lung problems?	None	Yes-list:
Any heart problems?	None	Yes-list:
Any kidney/urinary problems?	None	Yes-list:
Any bone/muscle problems?	None	Yes-list:
Any stomach/intestinal problems?	None	Yes-list:
Any brain/nervous system problems?	None	Yes-list:
Any genital problems?	None	Yes-list:
Any skin problems?	None	Yes-list:
Any eye/ear/nose/throat problems?	None	Yes-list:
Any developmental concerns or learning problems?	None	Yes-list:
Any behavioral problems or eating disorders?	None	Yes-list:
Any regular medications (over the counter or prescription)? List dose and frequency:		
Any other medical issues we should be aware of? None Yes-list:		
Females Only		
At what age did your child start her first period?		Does she have difficult periods?
Is your child on birth control?		Has your child had a miscarriage or abortion?

Child's Name:	Date of Birth:
BIRTH HISTORY	
Delivery: Vaginal Cesarean-due to:	Birth Weight:
Was this child premature: Yes No If yes, how many weeks?	Were there problems with this child's delivery? If yes, list:
Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc? If yes, list:	
Did this child need special treatment while in the hospital such as oxygen, transfusions, lights? If yes, list:	
Was (is) this child breast fed? Yes No	
Did (does) this child have any problems with breast feeding or formula feeding? If yes, list:	
SOCIAL HISTORY	
Who does this child live with (list names)? Relationship to child?	
Parents: Married Divorced Separated Single	
Siblings-please list:	
How many adults live in your home?	How many children live in your home?
Is your child currently enrolled in daycare or school? No Yes Where?	
Does your child participate in regular exercise? No Yes Explain:	
Does your child drink caffeine? No Yes	
Is there a swimming pool at home? No Yes	Any smokers at home? No Yes
Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No Yes
What is your water source?	Are guns kept in your home? No Yes
Does your child use seat belts/car seats? No Yes	Does your child wear a bike helmet? No Yes
Any pets in the home? No Yes If yes, list:	
Any other issues we should be aware of? No Yes If yes, list:	

Child's name:	Date of Birth:

FAMILY MEDICAL HISTORY

	Child's Father	Child's Mother	Sibling	Sibling	Grandparent	Other
Year of Birth (if known)						
Year of Death (if known)						
Cause of Death						
Heart Disease						
High Blood Pressure						
Stroke						
High Cholesterol						
Anemia						
Bleeding Disorder						
Diabetes (adult or child onset)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Social Problems						
Psychiatric Problems						
Cancer (type)						
Kidney Disease						
Migraines						
Seizures						
Congenital Birth Defects						
Eating Disorder						
Other:						

COMMUNICATION NEEDS

Language if other English: Child_____ Parent _____
Does your child have any special communication needs? No Yes-list:

PATIENT EDUCATION ASSESSMENT

How would you prefer patient education to be provided? Written or Demonstrated

PATIENT RIGHTS

Is there anything we need to know about your religion or culture in order to care for your child?
If yes, please explain: