Pediatric Medical History Form

Name: _____ DOB: _____ Age: _____ Date: _____

Grade in school _____

Reason for Today's Visit: _____

Past Medical History: (list all surgeries and hospitalizations)

1. _____
2. _____
3. _____

Problems for which you have seen a physician or been treated for: (please circle yes or no)

Cancer:	Yes (specify_____)	No
Respiratory:	Yes (specify_____)	No
Heart:	Yes (specify_____)	No
Thyroid:	Yes (specify_____)	No

Other: _____

Drug Allergies and Reactions:

1. _____ 3. _____
2. _____ 4. _____

Immunizations:

Up to Date? Yes No

Family History:

Age	Height	Weight	Age @ Puberty	Health Problems
Mother			(menses)	
Father			(shaving)	
Brother				
Sister				
Others				

Please note any family history of:

Tallness (Women > 5'10" and Men > 6') _____

Shortness (Women < 5' and Men < 5'3") _____

Calcium Problems (kidney stones) _____

Early Deaths _____

(Pediatric medical history continued….)

***Patient Name:_____ Date of Birth: _____**

Social:

Live w/Others	No	Yes	_____
Exercise:	No	Yes	Hours per week: _____
Smoke:	No	Yes	Amount/Day: _____
Alcohol:	No	Yes	Ounces/Day: _____
Sexually Active:	No	Yes	
Smoke Exposure	No	Yes	

Medications:

List any medications you are currently taking with dosage (include over the counter & vitamins or supplements:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Birth History:

Maternal health during pregnancy (specify):

Were there hospital stays? _____
Were there illnesses? _____
Drugs/substances used? _____
Medications prescribed? _____
Ultrasounds out of the ordinary? _____
Fetal movement normal? _____
Pre-Natal Care? Yes No
Prenatal vitmamins? Yes No

Neonatal:
Type of Birth (circle): vaginal C-Section
Birth weight: _____
Birth length: _____
Neonatal problems (circle): Resuscitation Jaundice Floppy

Home with Mom Extended hospital stay

What did you last eat for:

Breakfast:

Lunch:

Dinner:

Provider initials _____Reviewed completed forms with patient.