



PEDIATRIC HISTORY

Patient's Full Name: _____ Date of Birth: _____

ALLERGIES:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	
2. _____	
3. _____	
4. _____	

PAST MEDICAL HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> Acid Reflux Disease (or GERD) | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Psychiatric/Behavioral Problems |
| <input type="checkbox"/> Attention Deficit Disorder (ADD or ADHD) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Developmental/Learning Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Diabetes | |
| | <input type="checkbox"/> Genetic Disorder | |

MEDICATIONS:

List all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN (ie, once a day)
1. _____		
2. _____		
3. _____		
4. _____		

IMMUNIZATION HISTORY:

Vaccines are up-to-date as far as I know Yes No

List the previous physician/facility where vaccines were given so that we may try to obtain those records:

What city and state is that in? _____



FAMILY HEALTH HISTORY:

(Indicate with an "X" which family member has a history of which illness.)

	Mom	Dad	Brother(s)	Sister(s)
Asthma				
Diabetes				
Sickle Cell				
Bleeding Problems				
Seizures				
Heart Disease				
High Blood Pressure				
Psychiatric Disease				
Cancer (type)				

Other family health history that you think your physician should consider important information concerning your health (such as children with heart problems or genetic conditions):

SOCIAL HISTORY:

Nickname: _____

Mother's name: _____

Father's name: _____

Step-Mothers name: _____

Step-Fathers name: _____

Church/group Attended: _____

Lives at home with:

Father Mother Step-Mother Step-Father Siblings Extended Family

School Attended: _____ Grade: _____

PAST SURGICAL HISTORY:

	SURGERY	REASON	YEAR	HOSPITAL	SURGEON
1.	_____				
2.	_____				

Other hospitalizations? _____



PATIENT'S PRENATAL/BIRTH HISTORY:

Patient's birth weight: _____

How many weeks along was the pregnancy at the time of birth? _____

C-Section Vaginal Delivery Hospital of Delivery: _____

Complications with Delivery? _____

YOUR CARE TEAM:

List doctors you see regularly and their specialty:

Doctor _____ Specialty _____

Doctor _____ Specialty _____

Thank you for completing this form