PEDIATRIC HISTORY FORM

Name: _____ **D.O.B:**_____ **Sex: M F** **DATE:** _____

Other Healthcare Providers: _____

Birth History

Birth Order? _____

Where there any problems with the pregnancy or delivery of this child? If yes explain:

_____

_____

Length_____ Weight_____ Type of delivery: Vaginal_____ C-section_____ Breech_____

Problems (please circle): Jaundice Respiratory Distress Rash Feeding Problems Developmental Problems

Breast fed? Yes No If yes how long: _____

Hospitalizations/ Operations:

Hospital Reason Year

_____

_____

Medications and Dosages:

_____

_____

Allergies to any medications:

_____

_____

Are your child's immunizations up to date? Yes or No

Do you have their records? Yes or No

Social and Environmental History:

Who does the child live with? _____

Is the home tobacco free? _____ Are there smoke detectors in the home? _____

Seat belts used in your car? _____ Is your child in school or day care? _____

Does your child wear a bike helmet while riding? _____ Are there guns in the home? _____

Medical History: (please circle)

Anemia	Chicken Pox	Ear Problems	Eye or vision problems	
Asthma	Diabetes	Eczema	Kidney/Bladder problems	Rheumatic fever
Autism	Diarrhea	Epilepsy	Liver Disease/ Jaundice	Tuberculosis

Family History:

Please check all that apply	Father	Mother	Father's Parents	Mother's Parents	Siblings
Stroke					
Cancer					
Glaucoma					
Diabetes					
Epilepsy					
Mental Illness					
High blood pressure					
Bleeding disorder					
Heart disease					
Kidney disease					
Thyroid disease					
Parkinson's disease					
Alzheimer's disease					