Pediatric Medical History Form

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

PERSON COMPLETING FORM: _____ **RELATIONSHIP:** _____

MEDICATIONS: (Name, Dose, How many times a day)

_____

_____

ALLERGIES: (To what? What happens?)

_____

_____

IMMUNIZATION HISTORY: □ Fully immunized to my knowledge □ Delayed immunizations □ None

BIRTH HISTORY: Number of weeks gestation_____ Drug/alcohol use during the pregnancy: □No □ Yes
Major problems at delivery: □No □ Yes _____

HOSPITALIZATIONS: Has your child ever stayed overnight in a hospital?
□ No □ Yes (why?)_____

SOCIAL HISTORY: Any significant social history that you would like to share?

_____

_____

PERSONAL MEDICAL HISTORY:
Past significant problems: _____
Current significant problems: _____

OTHER PROVIDERS: (Please list any other specialists your child sees. Ex: physical therapy, ENT, etc)

_____

FAMILY HISTORY: Significant family history (parents, siblings, maternal/paternal grandparents, aunts, or uncles), such as alcohol, drug abuse, asthma, blood disorders, cancer, heart disease, developmental delay, diabetes, genetic disorder, cholesterol problems, HIV, scoliosis, seizures, stroke, thyroid?

_____

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