

Pediatric History Form

Name: _____ Date of Birth: _____

Sex:

Female
Male

Birth History:

Where there any problems with pregnancy or delivery of this child? **Yes** **No**

If yes, please explain: _____

_____ Term? _____ Premature?

Type of Delivery:

Vaginal _____ C-section _____
Length _____ Weight _____

Problems:

Jaundice Respiratory Distress
Feeding Problems Rash Breech
Developmental problems Please explain: _____

Hospitalizations/Operations:

Hospital	Reason	Year

Medications and Dosages:

Allergies to any medications?:

Please list:

Immunizations

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

Social and Environmental History:

Who does the child/children live with? _____

Is the home tobacco free? **Yes** **No**
Are there smoke detectors in the home? **Yes** **No**
Seat belts used in your car? **Yes** **No**
Is your child in school or day care? **Yes** **No**
Does your child wear a bike helmet while riding? **Yes** **No**
Are there guns in your home? **Yes** **No**
Do you have the poison-control center phone number near your telephone? **Yes** **No**

Medical History:

Check if your child/children have had any of the following:

- Asthma
- Anemia
- Chicken Pox
- Diabetes
- Chronic diarrhea
- Ear problems
- Eczema (overly dry skin)
- Epilepsy
- Eye or vision problems
- Kidney/Bladder problems
- Liver disease/Jaundice
- Rheumatic fever
- Tuberculosis
- Other (Please explain)

Family History

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