Pediatric Medical History Form

Name:	Date of Birth:	Date Form Completed:
PCP:		Name of Person completing form:

Pregnancy History: Did patient's mother use any of the following substances or have any of the following symptoms during pregnancy?

	Y	N	Don't Know	
Medications: Please name:				
Street drugs: Please name:				
Alcohol				
Smoking				
Vaginal infection				
Urine infection				
Other Problems:				

Birth History:

How long was the pregnancy?	
What hospital was the baby born at?	
What was the baby's birthweight?	
How long did the baby stay in the hospital?	
Was the delivery vaginal? D Yes D No D Don't know	
Did the baby have any problems? D Yes D No D Don't know	

Child's Medical History:

	Y	N	Don't Know	Notes
Has your child ever been hospitalized overnight?				
Has your child ever had surgery?				
Does your child have allergies? To What?				
Allergic to any medications?				List
Adverse reaction to medication?				List
Allergic to any foods?				List

Child's Medical History (cont.'):

	Y	N	Don't Know	Notes
Other allergies?				List
Does your child get regular dental care?				
Has your child gone to an ER this past year?				
Has your child ever had:				
Ear Infection?				
More than 2 Strep Throat?				
Pneumonia?				
Heart Problems?				
Chickenpox?				
Reaction to any immunization or medications?				
Urinary tract infections?				
Wheezing?				
History of oral steroids?				
History of albuterol use?				
History of daily controller inhaler?				
Please list any other major medical conditions and any current treatment/medications:				

SOCIAL HISTORY		
Mother's First Name:	Age:	Occupation:
Father's First Name:	Age:	Occupation
Parents Married? [] Yes [] No	Parents living together? [] Yes [] No	
Child's Daytime caregiver?		
Others living in your home?		
Siblings names, gender and ages:		
Smokers in household [ ]Yes [ ]No		
Water source: [ ] City [ ]Well [ ]Bottled [ ]County		
Pets: Type		

FAMILY HISTORY

Please check if there is a family history of the medical problems noted below
(mother, father siblings, grandparents, aunts, uncles and cousins)

Problem	Relationship	Maternal/ Paternal	Problem	Relationship	Maternal/ Paternal
☐ ADD		☐ M ☐ P	☐ Eczema		☐ M ☐ P
☐ Alcohol Abuse		☐ M ☐ P	☐ Heart Disease		☐ M ☐ P
☐ Allergy		☐ M ☐ P	☐ High BP		☐ M ☐ P
☐ Asthma		☐ M ☐ P	☐ Kidney		☐ M ☐ P
☐ Birth Defects		☐ M ☐ P	☐ Mental Illness		☐ M ☐ P
☐ Cancer		☐ M ☐ P	☐ Obesity		☐ M ☐ P
☐ Skin Cancer		☐ M ☐ P	☐ School Problems		☐ M ☐ P
☐ Cholesterol High		☐ M ☐ P	☐ Seizures		☐ M ☐ P
☐ Development		☐ M ☐ P	☐ Stomach/Bowel		☐ M ☐ P
☐ Diabetes		☐ M ☐ P	☐ Thyroid		☐ M ☐ P
☐ Drug Abuse		☐ M ☐ P			
Any other medical condition that "runs in the family"?					

DEVELOPMENT/ BEHAVIOR

Problems with eating?	☐ N ☐ Y	Problems in School?	☐ N ☐ Y
Problems with sleeping?	☐ N ☐ Y	Problems with peers/siblings?	☐ N ☐ Y
Problems with elimination?	☐ N ☐ Y	Problems with toilet training?	☐ N ☐ Y
Problems with temper?	☐ N ☐ Y	Problems with behavior?	☐ N ☐ Y
At what age did your child sit alone?		At what age did your child speak words?	
At what age did your child walk?			
Do you have any concerns about your child's development?			

SAFETY/ ENVIRONMENT

Does your child always wear a seat belt?	☐ N ☐ Y	Are there any smokers in the house?	☐ N ☐ Y
Does you child always wear a helmet?	☐ N ☐ Y	Does your home contain lead paint?	☐ N ☐ Y
Do you have working smoke detectors	☐ N ☐ Y	Do you have firearms in the house?	☐ N ☐ Y

OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH PHYSICIAN

Name of Previous Doctor:_____

Address: _____

Signature of person completing form: _____ Date:_____

PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORD