

PEDIATRIC MEDICAL HISTORY
(Please complete as accurately as possible)

NAME: _____ DATE OF BIRTH: _____ CHART #: _____
 DATE: _____ AGE: _____ SEX: MALE FEMALE

CURRENT MEDICATIONS/VITAMINS: None, Yes, list _____

ALLERGIES: None, Yes, list _____

BIRTH AND DEVELOPMENT-

Type of Delivery _____ Pregnancy Problems _____

Birth Weight _____ Birth Length _____ Breast/Bottle Fed _____

Problems after Birth _____

Sat up (month) _____ Stood _____ Walked _____ Words _____ Sentences _____ First Teeth _____ Toilet Trained _____

School Grade _____ School Marks _____

PAST ILLNESSES:	Yes	No		Yes	No		Yes	No
Measles			mumps			Chicken Pox		
Rubella			Rheumatic Fever			Scarlet Fever		
Strep Throat			Allergies			Hives		
Ear Infections			Frequent Colds			Seizures		
Asthma			Bronchitis/Pneumonia			Pneumonia		
Urine Infections			Constipation			Diarrhea		
jaundice			Bleeding Problems			Hepatitis		
Behavior Problems			Eczema			Anemia		
Overweight			Heart Problems			Lazy Eyes		
Hearing/Vision Problems			Dental Problems			Immunization Reactions		

SURGERIES _____ if yes, what surgeries - _____

HOSPITALIZATIONS _____ If yes, for what - _____

OTHER: _____

FAMILY HISTORY			HAS ANY BLOOD RELATIVE HAD:			
	Age	Health		yes	No	Who
Father			Heart Problems			
Mother			High Blood Pressure			
Brothers			Diabetes			
			Asthma/Eczema			
			Seizures			
			Mental Problems			
Sisters			Bleeding Problems			
			Alcohol/Substance			
			Other (please explain)			

SOCIAL HISTORY:

How many people live in your household? _____ Pets at home _____ Smokers at home _____

Does your child live in or regularly visit an old house built before 1960? Yes No

If yes, has the house recently had, is presently having, or will have renovations done? Yes No

Caretaker when not at school _____

Parents - Married Single Divorced Parents' Occupations: _____

ADDITIONAL COMMENTS: _____

