Pediatric Health History (Ages 1-17)

Child's Name: _____

Age:_____ Date of Birth:_____

Your Name: _____

Relationship to Child: _____

Medicines/Vitamins/Herbs/Home Remedies (please list):

_____

_____

_____

Allergies/Reactions to Medicines and Vaccines:

___No Known Allergies/Reactions ___Allergic to:_____

Pregnancy and Birth:

Where was your child born?_____

Is the child yours by __Birth ___Adoption ___Stepchild __Other(specify)_____

Please list any medical problems during pregnancy:

___None ___Specify_____

Delivery by ___Vaginal Birth ___Cesarean (Why?)_____

Birth weight_____ Birth length_____

Please list any medical problems during the newborn period:

___None ___Specify:_____

If premature, how early?_____

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Other problems:_____

Immunizations/Infectious Diseases

Please bring a copy of your child's immunization records to your appointment

Has your child had any of the following diseases? (Check all that apply):

____Chickenpox ___Measles ___Mumps

____Rubella ____Meningitis ___Tuberculosis(TB)

Development

At what age did your child

Sit alone _____

Walk alone _____

Say words_____

Toilet train_____

Girls only: Age at first menstrual period_____

Past Medical History

Describe any major medical problems and their dates:

Family History

List any family members (parent, sibling, grandparents, aunt or uncle) with any of the following conditions:

Genetic disorders_____ Asthma_____

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Diabetes_____ Cancer_____

Heart disease_____ Bleeding/clotting disorder_____

High blood pressure_____ High cholesterol_____

Social History

Who lives at home?_____

Are your child's parents ___Married ___Unmarried ___Divorced ___Separated

Mother's Occupation_____

Father's Occupation_____

Childcare situation: ___Parents __Other(specify)_____

Does anyone at home smoke? __Yes __No