



Pediatric Medical History

(Complete Entire Form) Please use BLACK Ink only.

Child's Name: _____

Reason for your visit _____

Date of Birth _____ Birth Weight _____ APGAR _____

Primary Care Doctor _____

Complications with pregnancy: none / hypertension / drug/alcohol use / bleeding / diabetes

Was the baby born prematurely? **No** **Yes** If yes, how early? _____
 Did the baby stay in the intensive care? **No** **Yes** If yes, How long? _____
 Was the baby on a ventilator **No** **Yes** If yes, how long? _____
 Did the baby have any bleeding in the brain? **No** **Yes**
 Hydrocephalus? **No** **Yes**

Please list any other **chronic health problems** of your child

Please list any **other specialists** who care for your child _____

Past Surgeries &/or Hospitalizations	Date	Complications



Child's Name _____

Current Medications:

Name of Medication	Dose	Times given

Medication or other ALLERGIES _____

Are *immunizations* up to date? **Yes** **No** _____

Most recent Height _____ Weight _____

Diet: ___ Normal for age ___ Formula or breast milk ___ by mouth ___ by tube

Family History: *Please circle those conditions present in siblings, parents and grandparents*

High blood pressure Heart disease Cancer Diabetes Kidney Disease
 Liver Disease Bleeding Problems Birth Defects

Explain _____

Have you been told your child has any delays in developing skills? **No** **Yes**



If yes, explain _____

Do you use child safety seats or seat belts? **No** **Yes**

Are any of the following **used in the home**? Tobacco Alcohol Recreational Drugs

Is there a history of **domestic violence**? **No** **Yes**

Child's Name _____

Systems Review: Please circle those symptoms that your child has currently or in the past.

Vision loss	Eye infections	Glaucoma
Eye crossing	Ear infections	Sinus Infections
Hearing Loss	Trouble Swallowing or Chewing	Mouth Sores
Throat infections	Headaches	Neck Pain
Meningitis	Seizures	Heart Murmur
High Blood Pressure	Chest Pain	Asthma
Pneumonia	Bronchitis	Turning Blue
Stomach Pain	Reflux	Constipation
Diarrhea	Jaundice	Urinary infections
Incontinence	Blood in Urine	Arm Pain
Trouble using arms	Numbness	Arm Stiffness
Leg Pain	Trouble using legs	Numbness
Leg Stiffness	Skin rashes	Skin Sores
Swollen Glands	Bleeding Problems	Growth problems
Diabetes	Cancer	Cerebral Palsy



Form completed by _____ Date _____

Relationship to child _____

I have reviewed the above information with the patient and care giver.

Medical Staff - *Signature*

Date