Pediatric Medical History

Date / /

Child's name______________________ Date of Birth_______ Sex___
Address__________________________ Social Security Number________________
____
____

Mother's name______________________ Father's name________________________
Mother's phone number_______________ Father's phone number________________
Child resides with__________________
Legal guardian______________________ Emergency contact____________________
Phone number______________________
List siblings and dates of birth
____
____
____

Allergies to medications, x-ray dyes or other substances No Yes
If yes, please list medicine and reaction _______________________________________
____
____

Birth History

Birth Weight___________ Full term or premature? Breast or bottle fed?
Complications during pregnancy or delivery? ______________________________

Medical History

Please list any chronic or significant medical problems, including hospitalizations and surgeries
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____
____
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Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

Family History

Please circle if there is a family history of the following: (include parents, grandparents and siblings)

Hereditary illnesses	Substance Abuse	Sudden Death	Diabetes
Heart Disease	High Cholesterol	High Blood Pressure	Cancer
Skin Cancer	Mental Disease	Other	

If yes, list family member, diagnosis and age when diagnosed.

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Prevention

Is your child restrained in a car seat?	No	Yes	If no, why not?_________
Does your child wear a bike helmet?	No	Yes	N/A
Are there smokers in your child's home?	No	Yes	
Are there pets in your child's home?	No	Yes	If yes, what kind?________
If there is a gun in your child's home, is it unloaded and out of children's reach?	No	Yes	N/A
Was your child's home built before 1950?	No	Yes	