Pediatric Health History Form

Date: _____

Patient name: _____
Patient birthday _____
Male _____ Female _____
Parents/Guardians name: _____
With whom does the patient live? _____
Mailing address:_____
Email (parent):_____
Phone number:_____

Name of Siblings and Ages:_____
Birth History
Pregnancy complications, if any: _____
Did mother smoke, use drugs, or alcohol? Yes No
Birth Weight _____
Length at Birth _____
Term or Preterm (circle one). "Term" is on or after due date.
Vaginal delivery or C-section (circle one)
Delivery Complications, if any: _____
Problems with baby after birth, if any: _____
_____

Family History- Circle any that apply.
Allergies/Asthma
Ear infections/tubes
Eczema
Seizure disorder
High Cholesterol
Learning/attention problems
High Blood Pressure
Depression/Anxiety
Heart disease/ Stroke
Drug/Alcohol abuse
Cancer
Mental Retardation
Anemia/ Bleeding disorder
Hearing loss/ deafness
Diabetes
Vision loss
(Continued on next page)

Thyroid problems
Kidney disorder
Gastrointestinal disorder
HIV/Hepatitis/ Tuberculosis

Patient's Past Medical History
Drug allergies? No Yes (medication & reaction)_____
Surgery or Hospitalization? Reason and Date_____
Has your child ever had chickenpox? Approximate date: _____
Current medications and dosage: _____

Review of Systems
Does the patient have or has ever had any of the following (circle and describe any that apply):

Allergies, Asthma or Respiratory Problems
Eye, Ear, Nose or Throat Problems
Heart Murmur or Heart Problems
Anemia or Bleeding problems
Abdominal Pain, Constipation, Vomiting or Diarrhea
Bladder or Kidney Problems
Skin Rashes or Problems (acne, eczema, etc.)
Headaches, Seizures, ADHD
Diabetes or Thyroid Problems
Fever, Decreased Activity, Poor Appetite
Behavior or Attention Problems
Other Problems