Pediatric History

Patient Name: ______________________
DOB: ______________________
Age: ______________________

Patients Previous Doctor: ______________________
Present Health Concerns: ______________________
Allergies to Medications: ______________________

Pregnancy

Maternal illness during pregnancy? ☐ Yes ☐ No
If so, what type? ______________________
Type of delivery? (circle one) C-Section / Vaginal
If C-Section why? ______________________
Medications: ______________________
Length of pregnancy: _______ weeks

Family History

Parents of the child in good health? ☐ Yes ☐ No
Siblings of the child in good health? ☐ Yes ☐ No

Please list medical conditions for the following family members:

Relative	Medical Conditions
Mother	
Father	
Siblings	
Siblings	
Siblings	
Maternal Grandparents	
Paternal Grandparents	

Social History

Are the parents of the child:
☐ Married ☐ Divorced ☐ Separated ☐ Deceased
This child lives with:

Name	Age	Relationship	Highest Education

Is the child in daycare, pre-school, nanny or relatives?
____

Social Questions	Yes	No
Are there pets in the home?		
Are there smokers in the home or people who smoke?		
Do you have a pool, spa, or pond?		
Does your child always use a car seat or seat belt?		
Does your child wear a helmet when riding a bike, etc.?		
Do you have a record of immunization?		
Is there violence in the home?		
Are there guns in the home?		
Any concerns with lead exposure		
Screen time per day? (TV, Computer, Phone, tablet, etc.)	___hrs / day	

Milk intake now: ☐ Cow milk (☐ non-fat ☐ 1% ☐ 2% ☐ whole) ☐ Other
Average ounces per day _______ oz

Birth History

Place of birth: ______________________
Adopted? ☐ Yes ☐ No Birth Weight:_______Length:_______
Problems at birth? ☐ Yes ☐ No Jaundice? ☐ Yes ☐ No
Breathing Problems? ☐ Yes ☐ No Antibiotics? ☐ Yes ☐ No
Other problems (explain)? ______________________
____
Stay in NICU? ☐ Yes ☐ No If so, why? ______________
Was child breastfed? ☐ Yes ☐ No If so, how long? ________

Past Medical History

Allergies? ☐ Yes ☐ No List Allergies ______________

Has your child had:	Yes	No
Frequent ear infections		
Eye problems		
Frequent colds, sore throats		
Asthma, pneumonia, recurring cough		
Heart murmur or heart problems		
Problems with urine infections		
Frequent diarrhea or constipation		
Convulsions / seizures		
Eczema or skin conditions		
Anemia or blood problems		
Feeding problems		
Has your child seen any specialists?		
Does your child homeopathic or herbal medicines?		

List other medical problems: ______________________
____

Age child: Rolled Over?_____ Sat Alone?_____ Walked?_____

If not applicable, leave blank	Yes	No
Was the child saying words by 18 months?		
Does the child have trouble sleeping?		
Has the child had trouble in school?		
Does the child get along with other children?		
Does your child suck his / her thumb?		
Does your child wet the bed?		
Any problems with toilet training?		
Hyperactivity?		
Nightmares or sleep issues?		
Speech problems?		
Problems with discipline?		

Medications child takes regularly:______________________
____

Hospitalizations & Operations
______________________ Date
______________________ Date
______________________ Date

Patient's Pharmacy: ______________________