

# PEDIATRIC MEDICAL HISTORY

DATE: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medications child is currently taking \_\_\_\_\_

Medication or Food Allergies \_\_\_\_\_

## **BIRTH HISTORY:**

Birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Length \_\_\_\_\_ Length of Time Pregnant \_\_\_\_\_ Vaginal or C-Section \_\_\_\_\_

Were there any problems with the pregnancy? \_\_\_\_\_

Did mother take any drugs or medications pregnancy? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Tobacco? \_\_\_\_\_ Other \_\_\_\_\_

Any problems at birth or in hospital nursery? \_\_\_\_\_

## **NUTRITION:**

Is or was child breast or bottle fed? \_\_\_\_\_ What formula? \_\_\_\_\_

Any feeding problems? \_\_\_\_\_

Do you or did you receive assistance from WIC? \_\_\_\_\_

## **GROWTH AND DEVELOPMENT:**

Age child sat alone \_\_\_\_\_ Walked alone \_\_\_\_\_ Toilet trained \_\_\_\_\_ Spoke in sentences \_\_\_\_\_

If child in school: School : \_\_\_\_\_ Grade: \_\_\_\_\_ Any problems \_\_\_\_\_

## **IMMUNIZATION:**

Are the child's immunizations up to date? YES NO *Please provide a copy of the immunization record to the clinic.*

## **SOCIAL HISTORY:**

Who is the legal guardian of the child? \_\_\_\_\_

Who lives in the home with the child? \_\_\_\_\_

If both parents/guardians work, who keeps the child? \_\_\_\_\_

Father's/Mother's/Guardian's occupation: \_\_\_\_\_

Does family drink water from city supply or well? \_\_\_\_\_

Has child, or anyone in the home, been subjected to neglect, physical, sexual, emotional or other abuse? If yes, what type, when, treatment, etc. \_\_\_\_\_

Has child, or anyone in the home, been subjected to domestic violence? If yes, explain. \_\_\_\_\_

Has child, or anyone in the home, been treated for mental health problems or alcohol, prescription or street drug use? If yes, when, type and/or quantity. \_\_\_\_\_

## **PAST MEDICAL HISTORY:**

*Has your child ever had any serious illnesses, hospitalizations, surgeries or serious injuries? If so, please list:*

## **FAMILY HEALTH:**

*Please give name & age of family members and state any health problems they may have:*

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

Is there any family history of: Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ Birth Defects \_\_\_\_\_ Epilepsy \_\_\_\_\_ Hyperactivity \_\_\_\_\_

Hay Fever \_\_\_\_\_ Mental Retardation \_\_\_\_\_ Heart Disease \_\_\_\_\_ Cancer \_\_\_\_\_ Kidney Disease \_\_\_\_\_ TB \_\_\_\_\_