Pediatric Medical History

Today's date _____

Full Legal Name of Child:_____ **Date of Birth** _____

Mother's Legal Name: _____ **Mother's Maiden Name:**_____

Father's Full Legal Name:_____

Please complete the following questions: ☑ Check any that apply or Indicate Yes or No.

My child is a ___ male or ___ female.

Does your child have **any drug or food allergies**? ____Yes ___No If yes, list: _____

What was your child's birth weight? _____lbs _____oz Was the birth: ___ Vaginal ___ Cesarean section

Were there complications at birth? __ Prematurity __ Newborn Infection __ Jaundice __Maternal diabetes __None

If any other complications, please explain:_____

Did mother use any of the following during pregnancy: __Alcohol __Tobacco __Cocaine __Other _____

Has your child ever had any developmental problems? ___Yes ___No ☑ **Check any that apply.**
___ Delayed speech ___ Delayed walking ___ Poor growth ___ Poor weight gain ___ Other: _____

Did your child have a new born blood screen test? __Yes __No Follow-up screen? __Yes __No

Are your child's immunizations up to date? ___Yes ___No ___Uncertain

Has your child had the Hepatitis B immunization? ___Yes ___No ___Unknown

When was your child's last tuberculosis skin test? (date) _____ I do not know? ____

Does your child take any regular medications? ___Yes ___No
If Yes, please list:_____

Does your child have any of the chronic medical illnesses listed below? **Circle Yes or No.**

Asthma	Yes	No	Anemia	Yes	No
Hay fever	Yes	No	Ear Infections (recurrent)	Yes	No
Epilepsy	Yes	No	Urinary Infections (recurrent)	Yes	No
Diabetes	Yes	No	Eczema	Yes	No
Attention Deficit Disorder	Yes	No	Pneumonia	Yes	No
Learning Disability	Yes	No	Seizures	Yes	No

Please list any other illnesses of your child: _____

Has your child had any surgeries? ___Yes ___No If yes, please list: _____

Does your child have any dietary restrictions? ___Yes ___No List:_____
Does your child take vitamins? ___Yes ___No ___ Sometimes
Do you have any concerns about your child's food intake? _____

Who is the primary care provider for this child? ___ Mother/father ____ Daycare ___ Relative ___ Other: _____

Is there anyone in the child's home that uses? _____ Tobacco ____ Alcohol ____ Illegal drugs ____ Guns

Are these available in your home? ____ Telephone ____ Automobile ___ Thermometer ___ Car Safety Seat

Family History: Are any of the following diseases present in any immediate family members? ☑ Check any that apply.

	Cancer (type)	Diabetes	High Blood Pressure	Heart Disease	(age of onset)	Stroke	If None Apply ☑ box
Father	_____	_____	_____	_____	_____	_____	☐
Mother	_____	_____	_____	_____	_____	_____	☐
Brother	_____	_____	_____	_____	_____	_____	☐
Sister	_____	_____	_____	_____	_____	_____	☐

Other questions/concerns about your child: _____

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