



Patient Name _____

Date of Birth: _____

PEDIATRIC PATIENT HISTORY FORM

BIRTH HISTORY

Delivery: Vaginal Cesarean - due to:	Birth Weight:
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Was this child premature? Yes No If yes, how many weeks? _____	Were there problems with this child's delivery? Yes No If yes, list:
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Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? If yes, please list:

Did this child need special treatment while in the hospital such as oxygen, transfusions, lights?

Was (is) this child breast fed? No Yes

Did (does) this child have any problems with breast feeding or formula feeding?

SOCIAL HISTORY (Circle the appropriate answers)

Parents: Married Divorced Separated Single

Siblings - please list:

How many people live in your home? _____ Adults _____ Children

Is your child currently enrolled in daycare or school? No Yes

Does your child participate in regular exercise? No Yes explain:

Does your child drink caffeine? No Yes

Is there a swimming pool at home? No Yes	Any smokers at home? No Yes
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Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No Yes
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Any pets at home? No Yes
If yes, please list:

What is your water source?	Are guns kept in your home No Yes
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Do all family members use Seat belts/care safety sets? No Yes	Do all family members use Helmets when biking? No Yes
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Any issues we should be aware of? No Yes Please list:

Parents Initials: _____

Date: _____

Medical Provider's Initials: _____

Date: _____

Patient Name _____

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MEDICAL HISTORY

Hospitalizations? None Yes - list:

Surgeries? None Yes - list:

Drug Allergies? None Yes - list:

Did you bring a copy of child's immunization record? No Yes If no, please provide as soon as possible.	Hepatitis B Vaccine? No Yes
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Has your child had chicken pox? No Yes If yes, when?	Has your child had chicken pox vaccine? No Yes
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Any Chronic Illnesses: none yes - list:	Has your child seen a sub-specialist? No Yes If yes, when?
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REVIEW OF SYSTEMS

Any lung problems?	None	Yes - list:
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Any heart problems?	None	Yes - list:
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Any kidney/urinary problems?	None	Yes - list:
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Any bone/muscle problems?	None	Yes - list:
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Any gastro-intestinal problems?	None	Yes - list:
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Any brain/nervous system problems?	None	Yes - list:
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Any genital problems?	None	Yes - list:
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Any skin problems?	None	Yes - list:
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Any eye/ear/nose/throat problems?	None	Yes - list:
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Any developmental concerns or learning problems?	None	Yes - list:
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Any behavioral problems or eating disorders?	None	Yes - list:
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Any regular medications (over the counter or prescription)? Include does and frequency.

Any medical issues we should be aware of? None Yes - list:

Parents Initials: _____

Date: _____

Medical Provider's Initials: _____

Date: _____

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FAMILY MEDICAL HISTORY

	Child's Father	Child's Mother	Sibling	Sibling	Grandparent	Other
Year of Birth (if known)						
Year of Death (if known)						
Cause of Death (if known)						
Heart Disease						
High Blood Pressure						
Stroke						
High Cholesterol						
Anemia						
Diabetes (note if onset as Adult or Child)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Social Problems						
Psychiatric Problems						
Cancer (type)						
Kidney Disease						
Migraines						
Seizures						
Congenital Birth Defects						
Eating Disorder						
Other:						
Other:						

COMMUNICATION NEEDS:

Language if other than English: Child _____ Parent(s) _____
 Any special communication needs? No Yes
 If yes, explain: _____

PATIENT EDUCATION ASSESSMENT:

Would you prefer patient education be provided to you or your child by:
 Demonstration
 Written Materials
 Other Explain: _____

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for your child? ____Y ____N
 If YES, explain: _____

Parents Initials: _____

Date: _____

Medical Provider's Initials: _____

Date: _____