PEDIATRIC ASSOCIATES

Pediatric Medical History Form

Child's Name:_____ Birth Date:_____

BIRTH HISTORY: Please fill in the blanks.

Hospital:_____ **Type of Delivery:**_____

Complications with Delivery:_____ **Birth Weight (If known):**____(lbs)____(oz)

Term:_____(wks) **Jaundice:** (yes / no) **Phototherapy:** (yes / no)

CHRONIC MEDICATIONS: Please list the child's dose and frequency of chronic medications.

_____

_____

_____

ALLERGIES: Please list any drug and/or food allergies, reaction if ingested, and date first noted.

_____

_____

PAST MEDICAL HISTORY: Please indicate any chronic conditions or problems of the child.

_____

_____

SURGERY: Please list any past surgeries and dates.

_____

_____

HOSPITALIZATION: Please list any past hospitalizations and dates.

_____

_____

SOCIAL HISTORY: Please answer the following questions.

Who lives in the household?_____

_____

Are there any pets in the home? If yes, what kind?

_____

Does anyone in the household smoke? _____

If yes, outside or inside?_____

Are there any guns in the home? _____

If yes, are they locked?_____

Are your child's parents married? If not, what is the custody arrangement?_____

Lead risk: What year was your home/apartment built?_____

TB risk: Has the child traveled or lived outside of the U.S. for longer than 2 weeks? If so, what country?_____

Is your child in daycare? If so, what kind (in-home, group, babysitter, nanny)?_____

Languages spoken at home?_____

Does your child visit the dentist every 6 months?_____

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DEMOGRAPHICS: Please list pertinent demographic information.

	Name	Age	Occupation	Highest Education	Ethnicity
Mother					
Father					

	Name	Age		Name	Age
Sibling 1			Sibling 3		
Sibilng 2			Sibling 4		

FAMILY HISTORY: Please indicate with a check (√) the specified relatives with any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
ADHD												
Anemia												
Autism												
Asthma												
Autoimmune Disease												
Birth Defect (type?)												
Bleeding Problems												
Cancer (type?)												
Depression												
Diabetes												
Eczema												
Endocrine Disease												
Food Allergy (which foods?)												
Genetic Disorder												
Heart Attack/Heart Disease												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Learning Disability												
Liver Disease												
Mental Health Problems												
Neurologic Problems												
Seasonal Allergies												
Seizures												
Stroke												
Substance Abuse												
Thyroid Disorders												
Death before age 50												
Other												