Pediatric Medical History Form

Please print (if you do not understand a question, leave it blank)

Today's date _____

PATIENT NAME _____
(First) (M) (Last) (Date of birth)

Name of your child's pediatrician or family doctor: _____ Clinic: _____

Is your child in good health? No ____ Yes ____ If no, please explain: _____

_____

Does your child have any current of past medical problems? (e.g. heart, lung, urinary tract, blood, immune system, etc.) No ____ Yes ____

If yes, please explain: _____

_____

Does your child have a specific named syndrome? No ____ Yes ____ If yes, please list: _____

Was there a problem during your child's pregnancy, labor and/or delivery? No ____ Yes ____ If yes, please explain: _____

_____

Child's height: _____ Child's weight: _____

Previous hospitalization(s)? No ____ Yes ____ If yes, please list: _____

Previous surgery? No ____ Yes ____ If yes, please list: _____

Current medications: No ____ Yes ____ Please list: _____

Allergies: Medications? No ____ Yes ____ Please list: _____

Hay fever, dust, etc.? No ____ Yes ____ Please list: _____

Foods? No____ Yes____ Please list: _____

Does your child have problems with excessive bleeding or easy bruising? No ____ Yes ____ If yes, please explain: _____

_____

Is there a family history of unusual or severe diseases or bleeding problems? No ____ Yes ____ If yes, please explain: _____

_____

Is your child in daycare? No ____ Yes ____ If yes, your child is in day care with (please check one) ☐ More than 10 children ☐ Less than 10 children

Are there any pets in the home? No ____ Yes ____ Please list: _____

Is there any other information you would like to share about your child? No ____ Yes ____ If yes, please explain: _____

_____

_____

_____

Physician use only: Date/Initials _____