Pediatric Medical History Form

(Birth through age 17)

	Today's Date:
Child's Name:	**Date of Birth:**

Mother's Name:	Occupation:	Daytime Phone:
Father's Name:	Occupation:	Daytime Phone:

Siblings' Names:	Date of Birth:

Daytime Childcare (circle):	Parent	Daycare Center	Babysitter/Nanny	School
Name of Caretaker:			Phone:	

Birth History:	
List any medical problems during pregnancy:	
Was your child fed by (circle): Breastmilk or Formula	Birth weight:
Method of delivery (circle): Spontaneous vaginal, C-section, Forceps/Vacuum assisted	
List any problems for your baby during the newborn period:	

Family History: please check any pertinent family history and list relation of any family members with the following:

☐ Asthma/allergies/eczema	☐ Learning disabilities
☐ Autism	☐ Obesity
☐ Bleeding disorders	☐ Psychiatric disorders
☐ Death at a young age	☐ Scoliosis
☐ Diabetes	☐ Substance abuse
☐ Genetic disease or birth defects	☐ Thyroid disease
☐ Heart disease	☐ Tuberculosis
☐ Hepatitis, HIV	☐ Other serious medical problems

Social History (circle):

Tobacco exposure at home Y / N	Guns in the home Y / N

IF YOUR CHILD IS A NEWBORN, YOU MAY STOP HERE

Medical History:

Significant medical problems through childhood (List names/types of specialist seen):

Hospitalizations or operations:

Severe injuries, broken bones, etc:

Current Medications (Prescription and Over the Counter):

Allergies (to Medications or Foods):

Nutrition/Feeding History:

List any past or present issues regarding your child's eating habits, nutrition, etc:

Developmental History:

Has your child met normal developmental milestones (language, social skills, motor skills, etc): Y / N
If no, please explain:

Do you have any behavioral concerns regarding your child : Y / N
If yes, please explain:

School History:

List any concerns regarding school performance:

List any extracurricular activities or sports:

Vaccination History:

Please provide a copy of your child's prior vaccinations

Have you refused vaccinations for any reason? Y / N If yes, please explain why:

Preventive Care:

Has your child had any sleep problems: Y / N If yes, please explain:

Does your child see a dentist: Y / N

Do you have any concerns regarding substance abuse or risky behaviors: Y / N
If yes, please explain: