Pediatric Health History Form (New Patient)

Patient's name: _____ Form completed by: _____

Date of Birth: _____ Age: _____ Your relationship to patient: _____

Today's date: _____

Birth history

Where was your child born? _____ Birth weight (lb or kg): _____

Delivered by ☐ vaginal ☐ C-section

Reason for C-section _____

Gestation at birth: ☐ full term ☐ preterm

Weeks at birth (if known): _____

Any complications during pregnancy or with delivery:

_____

_____

_____

Medical history

Medications your child is on: (daily or as needed)

_____

_____

_____

Allergies to medicines, foods, etc:

_____

_____

_____

Hospitalizations or serious injuries/illnesses:

Type *Age*

_____

_____

_____

Surgeries:

Type *Age*

_____

_____

_____

Please list any specialist your child is seeing: _____

Social history

With whom does your child live?

Relationship to child *Age* *Gender*

_____

_____

_____

_____

_____

_____

Is your child around any smokers?

☐ Yes ☐ No (If yes, whom?_____)

Are there any guns in the home?

☐ Yes ☐ No

If yes, are the guns locked up?

☐ Yes ☐ No

Please list any animals/pets in the home:

_____

_____

Parents are: ☐ married ☐ unmarried ☐ divorced ☐ other

Family history (check those that apply and list family member affected)

☐ Asthma _____

☐ Allergies _____

☐ Cancer (please list type) _____

☐ High cholesterol _____

☐ Heart attack _____

☐ Blood or clotting disorder _____

☐ Thyroid disease) _____

☐ Anxiety/depression _____

☐ Kidney disease _____

☐ Developmental delay/autism _____

☐ Eczema _____

☐ Diabetes _____

☐ High blood pressure _____

☐ Stroke _____

☐ Anemia _____

☐ Seizures _____

☐ Migraines _____

☐ ADHD _____

☐ Unexplained deaths _____

☐ Hearing/vision deficits _____