Pediatric Medical History

Name:____ **Date:**________________

Date of Birth:___________________ **Age:**_________ **Gender:** **Male** **Female**

Parent/Legal Guardian Name:____**Phone:**_______________________

Household *(circle appropriate answers)*

Please list those living in the child's home

Name	Relationship To child	Birth date	Health Problems

Any siblings not living at home? Yes No

Age:_______ Where they live:____________________

Age:_______ Where they live:____________________

Does child live with Biological Parents? Yes No

If No, who has custody?_________________________

If parents are separated, how often does the child see the Parent not living in the home?_____________________

Birth History *(circle appropriate answers)*

Birth Weight:_______ **Baby was born**: At-Term Early Late

Did Mother have any problems during pregnancy?

No Yes (explain)_________________________________

____

Did Mother use any of the following during pregnancy?

Tobacco Alcohol Illegal Drugs Medications

What was used:____

When it was used:______________________________________

Delivery was: Vaginal Cesarean

If Cesarean, why?____________________________________

Did the Baby have any problems right after birth?

No Yes(explain)______________________________

Was Baby able to go home with Mother from the hospital?

Yes No(explain)______________________________

Feeding: Breast Bottle

Development *(explain if you answer "Yes" to any questions)*

Concerns about your child's physical development? No Yes____

Concerns about your child's mental/emotional development? No Yes____

If your child is in school:

- Has he/she failed or repeated any grades in school? No Yes____
- Is he/she in special resource classes? No Yes____
- How is he/she doing in academic subjects?:____

General

Do you consider your child to be in good health today? No Yes____

Has your child ever had any serious illness or medical condition? No Yes____

Has your child had any surgery? No Yes____

Has your child ever been hospitalized? No Yes____

ALLERGIES your child may have:____

Please list any medications/vitamins/supplements that your child is currently taking:______________________________

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Anything else we should know?____

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