 Pediatric History Form

Welcome to our clinic! In order for us to serve you better, please fill out this medical history form as accurately as possible. Thank you!

Child's Name ____ Date of birth __________________

Gender ______ Language ______________________________________

Race/Ethnicity: ___Black ___White ___Asian ___Hispanic ___Other ____________

Medical History

Please list below any significant illnesses that have required hospitalization, or are ongoing problems, for which your child currently receives treatment. For example: Asthma, ADHD, Prematurity, Diabetes

Month/Year Diagnosed	Condition

Allergies

Does your child have any allergies to medications? If so, what are they allergic to and what type of reaction did they have? Is your child allergic to any foods? Do they suffer from seasonal allergies? Please indicate below.

Agent/Substance/Medication	Reaction

Medication List
Please include inhalers, medication patches, nasal sprays, over-the-counter meds and supplements.

Name	Strength (e.g. mg dose)	Formulation (e.g. liquid, tablet or capsule)	Dose (i.e. how many, e.g. 1 tab)	Frequency (e.g. once daily)

Family History
Indicate if any blood relatives have had any of these conditions: Alcoholism, Arthritis, Asthma, Hay Fever, Cancer, Cirrhosis, Diabetes, Emphysema, Epilepsy, Gout, Heart, High Blood Pressure, Kidney Disease, Kidney Stones, Migraines, Sickle Cell, Stroke, Suicide, Mental Illness, Thyroid, Tuberculosis, Blooding Tendency

Family Member	**Alive/Deceased**	**Year of birth**	**Medical conditions, if any**
Father			
Mother			
Brother 1			
Brother 2			
Brother 3			
Sister 1			
Sister 2			
Sister 3			
Paternal grandfather			
Paternal grandmother			
Maternal grandfather			
Maternal grandmother			

		Number		Number	Healthy?
Siblings	Brothers		Sisters		
Children	Sons		Daughters		

Additional family history:

Pediatric Social History

Who does the child live with? Include name and relationship of all persons in household:

Name	Relationship

Who has legal custody of this child? ____

Is your child on any special diets? ____

Is there a smoke detector in the house? ___Yes ___No

Do you have guns in the household? ___Yes ___No **If yes, do they have trigger locks?** _____

Is there tobacco use in the home (incl. chewing tobacco and/or smoking outside)? ___Yes ___No

Are there any pets in the home? ___Yes ___No **What type?** ________________________________

Do you routinely travel outside of the U.S.? ___Yes ___No **Where?** __________________________

Surgical History

Month/Year	Surgery

Hospitalizations

Month/Year	Reason