Today's Date: _____

PEDIATRIC PATIENT FAMILY HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Name/Relation of Person Completing Form: _____

PRENATAL HISTORY

Birth weight: _____ Length: _____ Birth Hospital/Location: _____

Did the infant stay longer than the mother? ☐ Y ☐ N

If so, why?: _____

Did mother have any illness during pregnancy? *(ex: German measles/rubella, flu, bladder/kidney infection)*

Type of infection: _____ *Month of pregnancy:* _____

Medication/treatment: _____

Were there any complications of the pregnancy? *(ex: diabetes, thyroid disease, toxemia, excessive bleeding)*

_____

Were there any complications of the labor or delivery? *(ex: prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breathe)* _____

FAMILY HEALTH HISTORY

Please check all that apply	Patient's Mother	Patient's Father	Patient's Sibling	Relative *Please write in*	If Deceased *Write Date*
SKIN: ☐ eczema ☐ psoriasis ☐ ichthyosis	☐	☐	☐		
EYES: ☐ blindness ☐ cataracts ☐ lazy eye	☐	☐	☐		
EARS: ☐ deafness ☐ ear infections ☐ deformities	☐	☐	☐		
NOSE/THROAT: ☐ sinus problems ☐ tonsillitis ☐ lack of sense of smell	☐	☐	☐		
MOUTH: ☐ cleft palate ☐ cleft lip	☐	☐	☐		
GLANDS: ☐ thyroid trouble ☐ diabetes (adult) ☐ diabetes (juvenile)	☐	☐	☐		
LUNGS: ☐ asthma ☐ cystic fibrosis	☐	☐	☐		
HEART: ☐ murmurs ☐ heart attacks ☐ congenital abnormalities ☐ high blood pressure	☐	☐	☐		
STOMACH/BOWEL: ☐ ulcers ☐ colitis ☐ lactose intolerance	☐	☐	☐		
KIDNEY/BLADDER: ☐ congenital abnormalities ☐ infections ☐ kidney stones	☐	☐	☐		
BONE OR JOINT DISEASE: ☐ rheumatoid arthritis ☐ osteoarthritis ☐ osteogenesis imperfecta	☐	☐	☐		
NEUROLOGICAL PROBLEMS: ☐ seizures ☐ paralysis ☐ strokes	☐	☐	☐		
CANCER: ☐ type(s):	☐	☐	☐		
DEVELOPMENT PROBLEMS:	☐	☐	☐		
OTHER:	☐	☐	☐		

I am a parent/guardian or authorized representative of the pediatric patient listed above and the information provided is true and correct to the best of my knowledge.

Signature of Person Completing Form: _____ **Date:** _____

Today's Date:

PEDIATRIC PATIENT HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

Nickname (if any): _____

Name of Person Completing Form: _____ **Relation:** _____

HOME & SCHOOL

Who lives at home? _____

If age appropriate does your child attend: ☐ Daycare ☐ Preschool ☐ Elementary or higher, Grade:____ ☐ None of the above

Specify school/daycare attending if applicable: _____

ILLNESSES: If marking yes to any of the following, please give date of occurrence and then describe in space below.

Have there been any hospitalizations?	☐ Yes: Date/Description: _____	☐ No
Have there been any major medical problems?	☐ Yes: Date/Description: _____	☐ No
Any childhood illnesses? (ex: chickenpox, measles, etc.) Fracture or other injury?	☐ Yes: Date/Description: _____	☐ No
Additional space if needed:	☐ Yes: Date/Description: _____	☐ No

GENERAL HEALTH

Name/Location of Previous Pediatrician: _____ Date Last Well Visit: _____

Are there specific concerns you wish to discuss? If So, list: _____

Medications (include frequency/dose/reason/prescriber): _____

Allergies: _____

Special Dietary Needs: _____

PLEASE HAVE IMMUNIZATION RECORDS SENT TO THE OFFICE OR ATTACH TO COMPLETED FORM.

(These can be obtained from previous medical provider or often times the child's school)

PATIENT REVIEW OF SYSTEMS: Please include date(s) of occurrence if applicable

Has she/he had frequent problems with any of the following *(please check and/or write in all that apply)*:

☐ **Head**	Headaches, dizziness, injury, other: _____
☐ **Eyes**	Vision problems, infection, pain, other: _____
☐ **Ears**	Hearing problems infections, pain, other: _____
☐ **Nose**	Frequent stuffiness, easy bleeding, other: _____
☐ **Mouth**	Tooth decay, poor bite, other: _____
☐ **Throat**	Frequent sore throat, trouble with swallowing, other: _____
☐ **Neck**	Stiffness, swelling, swollen glands, other: _____
☐ **Chest**	Deformity, pneumonia, cough, asthma, other: _____
☐ **Heart**	Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other: _____
☐ **Abdomen** ☐ **Urinary**	Vomiting, frequent pain, diarrhea, constipation, other: _____ Pain on voiding, voiding frequently, bed wetting, other: _____
☐ **Skin**	Rash, infection, other: _____
☐ **Neurological**	Development problems, seizures, meningitis, other: _____
☐ **Endocrine**	Weight gain/loss, intolerance to heat/cold, thirst, hair changes (thinning, falling out), other: _____
☐ **Arms & Legs**	Deformity, abnormal walking, joint pain, joint swelling, other: _____
☐ **Hematological**	Anemia, abnormal bleeding, other: _____