Pediatric Medical History

**Please attach a copy of vaccination records**

Child's Name: _____Date of Birth: _____
Gender: M/F Ethnicity: _____
Mother's Name: _____Father's Name: _____
Siblings Name's and birthdates: _____
Facility name and location of child's birth: _____
Birth weight: _____ Birth Length: _____Head Circ:_____
Delivery Type (circle one): Vaginal or C-Section Vacuum or forceps assisted: Yes/No
Pregnancy: Full Term/Preterm Breast fed Y/N If yes, now long? _____
Bottle Fed Y/N Formula Name(s)_____

**Pregnancy History (Please circle yes or no)**:

| | | | |
|---|---|---|---|
| Smoking | Y/N | Premature Labor | Y/N |
| Bleeding | Y/N | Preeclampsia | Y/N |
| Infections | Y/N | High Blood Pressure | Y/N |
| Toxemia | Y/N | Medication(s) | Y/N |
| Drugs/Alcohol | Y/N | Other: _____ | |

**Problems during child's newborn period (Please circle yes or no):**

| | | | |
|---|---|---|---|
| Jaundice | Y/N | Feeding problems | Y/N |
| Colic | Y/N | Infections | Y/N |
| Breathing problems: | Y/N | Other:_____ | |

**Developmental History:**

At what age did your child (approx): Sit up:_____Crawl:_____Walk:_____ First word:_____

**Family History (Please circle yes or no and indicate relationship to child):**

| | | |
|---|---|---|
| Asthma | Y/N | _____ |
| Anesthetic reaction | Y/N | _____ |
| Bleeding disorder | Y/N | _____ |
| Cystic Fibrosis | Y/N | _____ |
| Cancer (and type) | Y/N | _____ |
| Diabetes (type I or II) | Y/N | _____ |
| High cholesterol | Y/N | _____ |
| Heart disease | Y/N | _____ |
| High blood pressure | Y/N | _____ |
| Early/Unexplained death | Y/N | _____ |
| Muscular Dystrophy | Y/N | _____ |
| Sickle Cell Anemia | Y/N | _____ |
| Thyroid disease | Y/N | _____ |
| Other (explain): | Y/N | _____ |

Child's allergies to medications (note reaction for each): _____

Allergies to food(s) (note reaction for each): _____

Please list all medications currently taking: _____

_____

| Significant Illnesses/Injuries: | Hospitalized? | How long? |
|---|---|---|
| _____ | Y/N | _____ |
| _____ | Y/N | _____ |

**Child's past medical history (please circle yes or no):**

| | | | |
|---|---|---|---|
| Asthma | Y/N | Bleeding disorder | Y/N |
| Pneumonia | Y/N | Diabetes | Y/N |
| Chronic Cough | Y/N | Hepatitis | Y/N |
| Seasonal Allergies | Y/N | Chronic constipation | Y/N |
| Post nasal drip | Y/N | Chronic diarrhea | Y/N |
| Ear infections | Y/N | Stomach pain | Y/N |
| Ear tubes | Y/N | Swollen painful joints | Y/N |
| Nosebleeds | Y/N | Chronic muscle aches | Y/N |
| Eye surgery | Y/N | Bedwetting > age 3 | Y/N |
| Glasses | Y/N | Seizure disorder | Y/N |
| Contacts | Y/N | Headaches/Migraines | Y/N |
| Thyroid disorder | Y/N | Urinary tract infections | Y/N |
| Heart disease | Y/N | Learning disorder | Y/N |
| Heart murmur | Y/N | Behavioral disorder | Y/N |
| High cholesterol | Y/N | ADHD | Y/N |
| Heart surgery | Y/N | Other:_____ | |
| Anemia | Y/N | | |

Child care outside of the home? (Details): _____

**Testing**

| | | Date | | | Date |
|---|---|---|---|---|---|
| Chest X-ray | Y/N | _____ | CBC | Y/N | _____ |
| Fasting blood sugar | Y/N | _____ | Thyroid panel | Y/N | _____ |
| Cholesterol | Y/N | _____ | Hearing test | Y/N | _____ |
| Chemistry Panel | Y/N | _____ | Vision test | Y/N | _____ |
| Urinalysis | Y/N | _____ | TB (PPD) test | Y/N | _____ |

**Girls only:**

Age at first menstrual period:_____Date of last menstrual period:_____

Are periods regular? Y/N If no, please explain:_____