Pediatric Medical & Family History Form

Patient Name:	**Patient DOB:**	**Gender:** Male Female
Form Completed By:	**Relationship:**	Today's Date:

Allergies (include dates):	**Medications (include dosage):**	**Surgical History(include date/age):**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunization History: To the best of my knowledge, my child is ☐ No ☐ Yes

If no, why?

_____

_____

_____

Hospitalizations: Has your child ever stayed overnight? ☐ No ☐ Yes

_____

_____

_____

Patient's Daily Activities/Habits:	**No**	**Yes**
Blood Transfusion		
Caffeine Concerns		
Occupational Exposure		
Hobby Hazards		
Sleep Concern		
Stress Concern		
Weight Concern		
Follow Special Diet		
Exercise Regularly		
Wear Helmet on a bike		
Wears Seat Beat		

Newborn History

Birth Length _____ Birth Weight _____

Birth Head Circumference _____

Discharge Weight _____ Gestational Age _____

Cesarean Section ☐ No ☐ Yes

Apgars:

1 min _____

5 min _____

10 min _____

Primary Nourishment

☐ Bottle-fed

☐ Breast-fed

GYN History:

Age of first period ____ yrs

First day of last period _____

Has not had menses yet _____

Social History: Who lives at home?

Name	**Relationship**	**DOB**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____