PEDIATRIC HISTORY FORM

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

ALLERGIES/REACTION TO MEDICINE

_____

_____

_____

_____

VACCINATIONS _____

TETNUS ☐ YES ☐ NO LAST DATE: _____

PNEUMONIA ☐ YES ☐ NO LAST DATE: _____

FLU ☐ YES ☐ NO LAST DATE: _____

Food Allergies? ☐ YES ☐ NO _____

Latex Allergy? ☐ YES ☐ NO

HOSPITAL ADMISSION

YEAR	ILLNESS OR OPERATION/PHYSICIAN	YEAR	ILLNESS OR OPERATION/PHYSICIAN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

BIRTH HISTORY - PLEASE CHECK ALL THAT APPLY

Weight at Birth: _____

Full term: ☐ YES ☐ NO If premature, how early? _____

Was the delivery: ☐ *VAGINAL* ☐ *C-SECTION* ☐ *FORCEPS*

Any pregnancy complications? ☐ YES ☐ NO If yes, explain? _____

Any problems with the delivery? ☐ YES ☐ NO If yes, explain? _____

Any problems in the nursery? ☐ YES ☐ NO If yes, explain? _____

While pregnant did mother use? *ALCOHOL* ☐ YES ☐ NO *DRUGS* ☐ YES ☐ NO *CIGARETTES* ☐ YES ☐ NO

Was child breastfeed? ☐ YES ☐ NO If yes, how long? _____

SOCIAL HISTORY - PLEASE CIRCLE THE APPROPRIATE ANSWER AND EXPLAIN

Anyone smoke in the home?:	☐ YES	☐ NO	
Do parents/caregivers have problems with alcohol/drugs?	☐ YES	☐ NO	
Do parents/caregivers have any concerns about smoking/alcohol/drug use by child or his/her peers?	☐ YES	☐ NO	
Do parents (or adolescent) have concerns about sex/ birth control for adolescent?	☐ YES	☐ NO	
Are all medicines/chemicals out of reach?	☐ YES	☐ NO	
Is syrup of Ipecac available in home?	☐ YES	☐ NO	
Do parents know CPR?	☐ YES	☐ NO	
Does child use seatbelts/car seat every car ride?	☐ YES	☐ NO	Do parents? ☐ YES ☐ NO
Do you have smoke detectors/fire escape plan?	☐ YES	☐ NO	
Does child wear helmet when biking/roller blading?	☐ YES	☐ NO	Do parents? ☐ YES ☐ NO

FEMALES ONLY SKIP THIS SECTION IF PATIENT IS NOT MENSTRUATING.

Ever had a Pap Smear: _____ Last Menstrual Period: _____

Flow is: ☐ HEAVY ☐ MODERATE ☐ LIGHT Flow is: ☐ REGULAR ☐ IRREGULAR

Age of first menses _____ years old

How often are periods? every _____ days How long are periods? _____ days

FAMILY HISTORY - HAS ANY BLOOD RELATIVE SUFFERED FROM THE FOLLOWING? ☐ YES ☐ NO IF YES, LIST WHO: _____

☐ Heart Murmur	_____	☐ High Blood Pressure	_____
☐ Stroke	_____	☐ Heart Disease	_____
☐ Migraine	_____	☐ Skin Problems	_____
☐ Diabetes	_____	☐ Psoriasis/Eczema	_____
☐ Cancer	_____	☐ Liver Disease/Hepatitis	_____
☐ Arthritis	_____	☐ Lung Disease	_____
☐ Asthma	_____	☐ Tuberculosis	_____
☐ Sickle Cell Disease	_____	☐ Alcohol/Drug Abuse	_____
☐ Anemia	_____	☐ Mental Illness	_____
☐ Kidney Disease	_____	☐ Depression	_____
☐ Allergies	_____	☐ Thyroid Problems	_____
☐ Glaucoma	_____	☐ HIV/AIDS	_____

Signature of person completing form: _____

Date: _____

Relationship to Child: _____

OFFICE USE ONLY

DATE: _____

HISTORY REVIEWED BY: _____
SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT