



Medical History Form

Date: _____

Welcome to our pediatric practice! We look forward to providing the best care for your child from birth through college. Please complete this information for our records. Thank you.

Child's Name: _____ Date of Birth: _____

Birth History: Boy Girl Adopted

Birth Weight: _____ Birth Hospital/State: _____

Full-Term (≥ 37 wks) Vaginal C/Section due to _____

Premature (< 37 wks) # weeks _____ Forceps Vacuum

Pregnancy concerns: none _____

Newborn concerns: none jaundice other _____

Specialty Care:

Has your child ever seen a medical specialist? No ___ Yes ___

Please describe: _____

Special Interests/Hobbies/Activities:

sports _____ music _____

dance _____ art _____ scouts other _____

Past Medical History:

Does your child have a history of any medical conditions listed below? none
(please circle any that apply)

Genetic: chromosome abnormality

Growth: short stature overweight obesity

Development: delay-speech/language delay-motor skills autism

Learning: special education dyslexia

Behavior/Mood: ADHD anxiety obsessive-compulsive depression

Hearing: multiple ear infections ear tubes hearing loss

Vision: strabismus amblyopia myopia astigmatism cataract

Speech: delay-speech articulation stuttering speech therapy

Sleep: snoring sleep apnea sleepwalking recurrent nightmares

Neurologic: seizures migraines head trauma concussion

Respiratory: seasonal allergies asthma croup RSV pneumonia

Cardiac: heart murmur VSD ASD

Gastrointestinal: constipation acid reflux liver disease pyloric stenosis

Urology: bladder infections urinary reflux kidney disease enuresis

Muscle/Bone: club foot intoeing hypotonia scoliosis physical/occupational therapy

Dermatology: eczema acne warts molluscum hemangioma

Infectious: multiple strep throat meningitis tuberculosis HIV

Heme/Oncology: anemia leukemia cancer/tumor bleeding disorder clotting disorder

Other medical conditions: _____

Hospitalizations: none
Date_____ due to:_____
Date_____ due to:_____

Surgery: none
Date_____ due to:_____
Date_____ due to:_____

Current Medications: none
(name) (dose)

Allergies: none known Latex
(name -- type of reaction)
Medication_____
Food_____
Pets_____
Seasonal_____
Indoor_____

daily multivitamin
 other supplements_____

Family Hx:

Other Children (names/ages): _____

Please list any medical conditions of family members:
(ex: asthma, heart disease, high blood pressure, diabetes, obesity, cancer-type, acid reflux, lupus, arthritis, hypo/hyper-thyroid, hearing/vision problem, seizures/epilepsy, kidney problem, liver problem, melanoma, eczema, psoriasis, bleeding/clotting disorder, ADHD, depression, schizophrenia, Alzheimer's, etc.)

Mom_____
Dad_____
Sister/Brother_____
Grandparents_____
Cousins_____

Care/Education:

@home day care pre-school school grade_____ home school college

Home Environment:

Parents: married live together single-parent divorced remarried
Occupation: mom_____ dad_____
Guns: no yes -- locked away?_____
Smokers: no yes -- inside outside
Home: house apartment condominium
Pets: no yes -- type?_____

Please describe any specific concerns you would like to discuss regarding your child:

How did you find out about our pediatric practice?
