ABClinic Family Cares, Inc.
PEDIATRIC Medical History Information
(age 17 and younger)

Patient's Name ____ Date of Birth _____________ Age ______

Address ____ City ______________ State ________ Zip ________

Sex: ______Male ______Female

Pharmacy Name ____ Pharmacy #(_____)_________________________

BIRTH HISTORY (PATIENT'S)

If premature, number of weeks gestation when born:_____________

Type of Birth: ____ Vaginal ____ C-Section Birth weight _____________

Complications during pregnancy or birth? ______ If yes, explain: ____

PAST MEDICAL HISTORY

Do you have concerns about your child's general health? ___ No ___ Yes
If yes, please specify: ____
Is your child allergic to any medications? ______No _____Yes, which ones (list REACTION also)? __________________
________________ ____

Does your child have a history of:

☐ Anemia
☐ Asthma
☐ Attention Deficit/Hyperactivity
☐ Behavior Problem (type _______)
☐ Bleeding Disorders
☐ Ear Infections
☐ Cancer (type ___________)
☐ Diabetes
☐ Kidney Disease
☐ Growth Problem
☐ HIV
☐ Infections (type _____)
☐Seasonal or Food Allergies (to ____________)
☐ Stomach problem (type ______________)
☐ Strep throat
☐ Thyroid problem
☐ Other ________________

Please list any surgeries your child has had and the approximate dates: ____

____

Has your child ever been hospitalized? ___No ___If yes, for what reason? ____________________________________
List medications your child takes and the dosages:

____

____

____
____

____

Are your child's immunizations up to date? __ No ___ Yes ___ Don't know
Please provide our office with a copy of your child's immunization records.

FAMILY MEDICAL HISTORY

	Father	Mother	Child	Sibling	Grandparent	Other
Alcoholism	□	□	□	□	□	□ □
Asthma or Allergies	□	□	□	□	□	□ □
Bipolar Disorder	□	□	□	□	□	□ □
Bleeding Disorder	□	□	□	□	□	□ □
Cancer: type _______________	□	□	□	□	□	□ □
Depression, Anxiety	□	□	□	□	□	□ □
Diabetes	□	□	□	□	□	□ □
Heart Disease	□	□	□	□	□	□ □
High Blood Pressure	□	□	□	□	□	□ □
Kidney Disease	□	□	□	□	□	□ □
Mental Illness	□	□	□	□	□	□ □
Osteoporosis	□	□	□	□	□	□ □
Stroke	□	□	□	□	□	□ □
TB	□	□	□	□	□	□ □
Thyroid Disease	□	□	□	□	□	□ □
Other	□	□	□	□	□	□ □

SOCIAL HISTORY

Who lives at home with your child:
____

Does anyone at home smoke? ___No ___Yes

What grade is your child in? ____ If preschool-aged, who is the daytime caretaker?
____

Are there any problems at school? ___ No ___ If yes, specify:
____

Date: ___________ Parent Signature (or Legal Guardian) ________________________________