

**Patient History- Pediatric**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions so we will be better able to help you assess and take care of your child’s health. All answers will be confidential.

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Living in home? \_\_\_ Yes \_\_ No

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Living in home? \_\_\_ Yes\_\_\_ No

Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Living in home? \_\_\_ Yes\_\_\_ No

Is your child adopted? \_\_\_ Yes\_\_\_ No If yes, age at the time of adoption:

Has your child had an allergic reaction to any drugs? Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ If yes, what is (s)he allergic to?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any other allergies (food, dust, pollen, bee or insect stings, feathers, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have, or has (s)he had, any of the following?

Skin problems of long duration Bronchitis/Pneumonia Behavior problems

-Eczema -Asthma -Temper tantrums

-Hives -Hay Fever -School problems

-Frequent fevers -Heart murmur - Sleeping problems

-Eye problems/trouble seeing -Stomach aches/ Eating paint

-Ear infections -constipation/ diarrhea -Anemia

-Kidney/bladder problems -Sickle Cell Anemia -Diabetes

-Hearing problems -Hernia

-Speech problems -Hip/leg/foot abnormalities -Jaundice

-Tuberculosis - Convulsions -Frequent coughing -Chicken Pox

Are there any other problems you would like to discuss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What prescription and non-prescription medicines is your child currently taking regularly? (Be sure to include such medicines as vitamins, iron, etc.)

Was the pregnancy with this child: \_\_\_normal \_\_\_difficult?

How many weeks were you when the child was born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the child’s birth weight? \_\_\_\_\_\_\_\_\_lbs. \_\_\_\_\_\_\_oz.

What milk is the child currently on?

other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did your child have any problems during the first months of life (colic, feeding problems, loose bowels, vomiting, jaundice, etc)? \_\_\_Yes \_\_\_No

If your child has been in the hospital for a medical or surgical reason, complete the following (use a separate sheet if you need more space)

Date City State Hospital Reason

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions about the health of your child’s immediate family (use a separate sheet if you need more space):

Living Date of Birth Dead Age at Death Current Health/Cause of Death

Mother \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Father \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Brothers & Sisters

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

When your child rides in the car, does he/she ride in a car seat or wear a seat belt?

Is there any additional information which you think should be in your child’s medical record?