Pediatric Health History Form

Please answer the following questions. If you are uncomfortable with any questions, you don't need to answer it. Your answers are NOT shared with anyone.

Child's Name: ___________________________ Date of Birth: _________________ M/F _______

Mother's Name: __________________________ Education:_____________________ Occupation:_________________

Dad's Name: ____________________________ Education:_____________________ Occupation:_________________

Past History

Hospitalizations:____ Illness: _________________________________

Surgeries: (include Circumcision) _________________________________ Chronic Disorders: ________________________

Allergies (Medication or foods) ____

Medications/Supplements your child is on: (please include dosage) ____

Learning disability/difficulty:________________________________ Developmental delay: _________________________

Birth Hospital: ________________________ Birth weight: _____________________ Gestational Age: _____________

Was NICU required: Yes/No If yes why: _____________________________________ How Long: _____________

Delivery: ☐ Vaginal ☐ C- Section If C- Section Why: _____________________________________

Were there any prenatal or neonatal problems: ____

Social History

Siblings: Name _____________________________ Age: _______________ M/F

Name: ____________________________ Age: ________________M/F

Name: ____________________________ Age: _______________ M/F

Living situation if not living with both biological parents: _____________________________________

Day Care: (type) ____________________________ Special Diet: _____________________________

School:_____________________________ Grade:_________________ Any problems:______________________

Child's Extracurricular activity: (Please Circle) Sports/ Scouts/ Youth group/ Theater/ Musical instrument/ Cheer Gymnastics/ Dance/ Martial arts/ Other ______________________

How would you describe your child's activity level: (older child) _______________________________

Smoking and/or Vaping in the house: Y/N Marijuana use in the house: Y/N Always use seat belt or car seat: Y/N

(For older child) Alcohol Use: Y/N Drug Use: Y/N Sexual Activity: Y/N

Preferred Pharmacy Name: _____________________________ Address: ___________________

City or Zip: _______________________ Phone No: _____________________________

Is there anything else we should know about your child?

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Family History Acc#:__________________

Please indicate with an (x) family members who have had any of the following conditions.

	Child	Child's Mom	Child's Dad	Child's Sister	Child's Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
ADHD/Learning Disorder									
Asthma									
Autoimmune Disorder									
Bleeding Disorder									
Cancer (type)									
Cystic Fibrosis									
Congenital Anomaly/Birth									
Depression									
Diabetes Type 1									
Diabetes Type 2									
Genetic Disorder									
Hearing Disorder									
High Cholesterol									
High Blood Pressure									
Immune Disorder									
Kidney Disease									
Mental Health Issues									
Seizures									
Smoking									
Substance Abuse									
Thyroid Disorder									
Other									