PEDIATRIC HISTORY

Reason for your child's visit today: (chief complaint)_____

_____

Medical History: (please check box if your child has or has had the following)

☐ Head Injury	☐ Trouble seeing	☐ Trouble Hearing	☐ Frequent Ear Infections/Cold
☐ Trouble Talking	☐ Frequent Sore Throats	☐ Heart Murmur	☐ Trouble Breathing
☐ Pneumonia	☐ Bronchitis/Asthma	☐ Chronic Cough	☐ Frequent Abdominal Pain
☐ Broken Bones	☐ Frequent Vomiting	☐ Seizures	☐ Frequent Constipation
☐ Frequent Diarrhea	☐ Severe Headaches	☐ Trouble with coordination	

Please give the dates of those marked as well as hospitalizations or surgeries:_____

_____

_____

Medications (include vitamins and herbals):

Name:_____ Strength_____ Amount/day:_____

Name:_____ Strength_____ Amount/day:_____

Name:_____ Strength_____ Amount/day:_____

Has your child had an unusual reaction to any medications? ☐ **Yes** ☐ **No**, if yes what? _____

Allergies:_____

Is your child up to date on immunizations? ☐ **Yes** ☐ **No**

Has your child had any unusual reactions to any immunizations? ☐ **Yes** ☐ **No**, if yes what?_____

If any blood relative of the child has one of the following, please check:

	Father	Mother	Sister	Brother	Father's parents	Mother's parents
Asthma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Cancer , Type_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____
Kidney Problems	_____	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____	_____
TB	_____	_____	_____	_____	_____	_____
Chemical Dependence	_____	_____	_____	_____	_____	_____

Other, Explain_____

Was there anything unusual about this pregnancy, labor, delivery or problems during hospital stay?_____

_____

Did you have any concern about your child's development, school performance, or behavior?_____

_____

Are there smokers living in the home? ☐ **Yes** ☐ **No**

_____ _____

Guardian Name **Date**