Pediatric Medical History Form

Please print (if you do not understand a question, leave it blank)

Today's date ____________________

PATIENT NAME ____

(First) (M) (Last) (Date of birth)

Name of your child's pediatrician or family doctor: ______________________ Clinic: ______________

Is your child in good health? No ____ Yes ____ If no, please explain: ______________________

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Does your child have any current of past medical problems? (e.g. heart, lung, urinary tract, blood, immune system, etc.) No ____ Yes ____

If yes, please explain: ____

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Does your child have a specific named syndrome? No ____ Yes ____ If yes, please list: ______________

Was there a problem during your child's pregnancy, labor and/or delivery? No ____ Yes ____ If yes, please explain: ______________

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Child's height: __________ Child's weight: __________

Previous hospitalization(s)? No ____ Yes ____ If yes, please list: ______________________

Previous surgery? No ____ Yes ____ If yes, please list: ______________________

Current medications: No ____ Yes ____ Please list: ______________________

Allergies: Medications? No ____ Yes ____ Please list: ______________________

Hay fever, dust, etc.? No ____ Yes ____ Please list: ______________________

Foods? No____ Yes____ Please list: ______________________

Does your child have problems with excessive bleeding or easy bruising? No ____ Yes ____ If yes, please explain: ______________

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Is there a family history of unusual or severe diseases or bleeding problems? No ____ Yes ____ If yes, please explain: ______________

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Is your child in daycare? No ____ Yes ____ If yes, your child is in day care with (please check one) ☐ More than 10 children ☐ Less than 10 children

Are there any pets in the home? No ____ Yes ____ Please list: ______________________

Is there any other information you would like to share about your child? No ____ Yes ____ If yes, please explain: ______________

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Physician use only: Date/Initials ______________