Pediatric Clinical History Form

Date: ______________________________

Patient Name: ____ Date of Birth: ______________________

** An accurate medical, social and family history is very important for us to know in order to better assess your current medical health and influences on future health and well-being.*

Does your child have, or has he/she ever had the following? If so please provide details below:

Chickenpox Disease
Allergies
Asthma
Bronchitis
Bronchiolitis
Anemia or bleeding problems
Constipation
(for girls) Has she started her menses
(for girls) Any problems with her periods
Frequent headaches
Diabetes
Frequent ear infections
Problems with eyes or vision
Pneumonia
Blood transfusion
Bladder or Kidney infection
Seizures
Thyroid or other endocrine problem
Problems with ears or hearing
Frequent strep throat or snoring
Heart problem or heart murmur
Frequent abdominal pain
Bedwetting after 5 years of age
Any skin problem
Other neurological problems
Exposure to tobacco smoke
Any other significant problem

Please provide details here:

____
____
____

Gestational age at birth (What week during the pregnancy was this child born?) ______________________________

Was your child a twin or triplet? ____________________ Birth Weight? ____________________________ Birth Length? ____________
Did your child receive a vitamin K injection at birth? ________________ Did your child receive erythromycin eye ointment at birth? __________
Did your child receive their first Hepatitis B vaccine at birth? ______________________
Were there complications during the delivery? If so, please provide details: ____

Were there complications during the pregnancy with this child? If so, please provide details: ______________________________
Did the biological mother use alcohol or recreational drugs during pregnancy with this child? ___________________________
Did the biological mother smoke cigarettes during pregnancy? ____
Did the biological mother take medications during pregnancy? If so, which ones: _______________________________________

List Allergies and Reactions: NONE MEDICATIONS LATEX FOOD OTHER

______________________________ ______________________________
______________________________ ______________________________

Medication Dose/Number Per Day	Medication Dose/Number Per Day	Medication Dose/Number Per Day
1. ____________________	3. ____________________	5. ____________________
2. ____________________	4. ____________________	6. ____________________

Please list your preferred pharmacy: ____
Patient Name: ____________________________________ Date of Birth: ________________

Date of last dental exam: ____________ Date of last eye exam: __________

Immunizations:
In addition to these questions, please provide a complete immunization record to your provider
Do you vaccinate your child? ____________________ Do you follow the standard childhood vaccination schedule? ____________
In what state did your child last receive vaccinations? ________________

SURGERY	DATE	SURGERY	DATE
____________	____________	____________	____________
____________	____________	____________	____________

Illness Which Family Members? Illness Which Family Members?
Key: *MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather*

Cancer/Type? ____
Hypertension ______________________ Heart Disease ______________________
Diabetes ______________________ Stroke ______________________
Mental Disease ______________________ Alcoholism ______________________
Glaucoma ______________________ Bleeding Disorder ______________________
Osteoporosis ______________________ Thyroid Disease ______________________
Other ____

Father: Living / Deceased Age ____ Cause of Death ____________ Brothers: # Alive ____ # Deceased____ Age____ Cause of Death ________
Mother: Living / Deceased Age ____ Cause of Death ____________ Sisters: # Alive ____ # Deceased____ Age____ Cause of Death ________

Spiritual and/or Religious Preference (*optional*): ____

Parent's Occupations: ____

Parents Marital Status:

- Married
- Divorced
- Unmarried, living together
- Unmarried, not living together

Who does the child live with?

- Mother & Father
- Mother
- Father
- Joint Custody/Lives with both
- Other:____________________

Other Living Arrangements:

- Is Adopted
- In Foster Care
- Other: ____________________

Who lives in your current household? ____

____

____

______

Does anyone in the household smoke? ____________________ Does your child go to daycare?____________________

Do you use a babysitter?____________________ Which school does your child go to?____________________

What grade is your child in? ____________________ Does your child have difficulty sleeping? ____________________

How many hours of sleep does your child get each night? ____

Does your child take naps during the day? If so, how many hours per day? ____

Hobbies/Recreation ____

Exercise: None Type of Exercise: ____

Frequency: Days per week/Time per session ____