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.*

Past Medical History

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

- Chickenpox
- 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:

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Birth (Labor/Delivery) History

Gestational age at birth? ________________________ 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:____

Pregnancy History

Were there complications during the pregnancy with this child? If so, please provide details: _______________________________________

Did the mother use alcohol or recreational drugs during pregnancy with this child? ____

Did the mother smoke cigarettes during pregnancy? ____

Did the mother take medications during pregnancy? If so, which ones: ____

Allergies

NONE MEDICATIONS LATEX FOOD OTHER

List Allergies and Reactions:

____ ____

____ ____

Prescription/Non-prescription Medications/Vitamins/Supplements

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: ____________________

Prevention

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? ________________________

Past Surgical History

SURGERY	DATE	SURGERY	DATE
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Family History

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 _________

Social History

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 Father Other:___________________________
Mother Joint Custody/Lives with both
Other Living Arrangements:
Is Adopted In Foster Care Other: __________________________
Who lives in your current household? ____
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____
Does anyone smoke in the home? ________________________________ 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 ____