

PEDIATRIC HISTORY FORM

Name: _____ Age: _____ DOB: _____

Mother's Name: _____ Father's Name: _____

Address: _____

Child lives with (list everyone living in home and their ages):

Who stays with child during day: _____

Does anyone at home smoke? Yes No Is your child in day care? Yes No

Birth Weight: _____ Type of delivery: Vaginal or Vacuum-assisted or Cesarean

Mother's age at delivery: _____ Place of birth: _____

Problems during pregnancy, delivery or after birth:

Allergies (medicines, foods, dust, etc.) _____

Hospitalizations or Surgeries:

Ongoing Medical Problems:

Current medications:

Immunizations (please list or provide copy of **current** immunization record):

	1	2	3	4	5
DTAP:	_____	_____	_____	_____	_____
DT booster:	_____	_____	_____	_____	_____
HIB:	_____	_____	_____	_____	_____
IPV (polio):	_____	_____	_____	_____	_____
Hepatitis B:	_____	_____	_____	_____	_____
Hepatitis A:	_____	_____	_____	_____	_____
Pneumococcal:	_____	_____	_____	_____	_____
MMR:	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____
(chicken pox):	_____	_____	_____	_____	_____
Meningitis:	_____	_____	_____	_____	_____

Has your child or any blood relatives had the following illness? Who?

Anemia _____ Diabetes _____

Sickle Cell Anemia _____ High blood pressure _____

Asthma _____ Kidney disease _____

Allergies/Hayfever _____ High cholesterol _____

Bleeding problems _____ Seizures (epilepsy) _____

Mental illness _____ Cancer _____

Tuberculosis _____ Alcohol or Drug Abuse _____

Chicken Pox _____

Other: