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PEDIATRIC HEALTH & HISTORY

Name: _____ Age: _____ Date: _____
 Parents Name: Father _____ Mother _____
 Address: _____
 Phone: _____ Email: _____

PAST SURGICAL HISTORY:

List all surgeries (including date or age when surgery done):

1. _____
2. _____

PAST MEDICAL HISTORY:

Circle if you have had any of the following medical problems:

ALLERGIES	MENINGITIS	CHILDHOOD ILLNESS:	OTHER ILLNESSES:
EPILEPSY (SEIZURES)	ASTHMA	MEASLES (GERMAN) (10 DAY)	_____
ANEMIA	HEART MURMUR	MUMPS	_____
SCOLIOSIS	HIVES OR ECZEMA	CHICKEN POX	_____
DIABETES		WHOOPIING COUGH	_____

List all prescribed medications and dosages:

1. _____
2. _____

Vaccinations: Date of last Tetanus _____ Polio _____ Flu Shot _____
 Please bring copy of vaccination sheet

List all allergies to: Medications _____ Environment or Food _____
 Do you live with both parents? _____ Who else lives in your household? _____
 Places you have lived _____
 What school do you attend? _____
 Religious Preference _____ Active _____ Inactive _____

LIFESTYLE:

Has child ever had a drinking or drug problem? _____
 How frequently does child consume alcohol? _____ Last Drink? _____
 Does child smoke? _____ Packs per day _____
 Did child smoke in the past? _____ Quit when? _____
 Are there smokers in the house? _____
 Diet: Favorite foods: _____ Least favorite foods: _____
 Favorite Receptions: _____
 Is child involved in sports? _____ Which Sports? _____
 How much time does child spend on computer? _____ TV? _____ Video Games? _____

FAMILY MEDICAL HISTORY:

	Health	Age if Living	Age at Death	Cause of Death	Circle any diseases that any blood relatives have:	Which Relative
Father	_____	_____	_____	_____	Cancer	_____
Mother	_____	_____	_____	_____	Diabetes	_____
	_____	_____	_____	_____	High Blood Pressure	_____
	_____	_____	_____	_____	Heart Problems	_____
	_____	_____	_____	_____	Stroke	_____