Pediatric and Family History Form

Patients Name
Patient's Date of Birth Today's Date:
Name of person completing this form
Relationship to the child Is this child adopted Y N
Birth History
Any problems with pregnancy, labor, or delivery
If yes, please explain
Birth Weight:
Birth: Vaginal or C-Section Breastfeeding or Bottle Feeding
Family Medical History
Does anyone in the immediate family smoke Y N
Are there any guns in the home Y N

Is there any family history of any of the below? If yes, please describe in detail the relationship to the patient.

❑ Seizures	❑ Alcoholism	❑ Mental Retardation	❑ Cataracts
❑ Depression	❑ Hearing Abnormalities	❑ Thyroid Disease	❑ Diabetes
❑ Retinal Disease	❑ Allergies	❑ High Blood Pressure	❑ Tuberculosis
❑ Heart Disease	❑ Liver Disease	❑ Eczema	❑ Intestinal Problems
❑ Asthma	❑ Cancer	❑ Kidney Disease	❑ Immune Disorders
❑ Cystic Fibrosis	❑ Urinary Tract Issues	❑ Blood Disorders	
❑ Skin Disorders	❑ ADD/ADHD/Learning Disabilities	❑ Psychiatric Disorders	
❑ Hepatitis			
❑ Headaches			

Describe any other family history not mentioned:

_____

_____

Past Medical History:
Has your child ever been hospitalized?
Had any surgeries?
Seen a Medical Specialist
Had any allergic reaction to food?
Had any allergic reactions to insect bites/stings?
Medications
Is your child on any daily medications? Please List:
Medication: _____ Strength: _____ How Often: _____
Medication: _____Strength:_____How Often:_____
Medication: _____Strength:_____How Often:_____
Allergic/Reactions to any Medications?
_____

Updated 10/2017