PEDIATRIC HISTORY

This form to be initiated at first patient visit and updated at subsequent Well Child exams.

Name ____________________

DOB ____________________

Medical Record # ____________________

Date initiated ____________________

BIRTH HISTORY		MOTHER'S PRENATAL HISTORY
Birth weight	Type of Feedings	General Health?
Length	Gestational age	Any Bleeding During pregnancy ?
Head	Apgar scores	Any serious illness during pregnancy
Type of delivery / Any complications		Any X- Rays (other than routine ultrasound)?
		Any drugs taken during pregnancy (prescription, over the counter, illegal)?

FAMILY HISTORY

Parents	DOB Age	General Health
Mother		
Father		
Siblings		

PRIOR HOSPITALIZATION/SURGERY/SERIOUS ILLNESS

Date	Condition	Date	Condition
			Chicken Pox

FAMILIAL DISEASES

Alcoholism	
	Kidney Disease, (frequent infections; Nephritis)
Allergies	
	Mental Illness
Birth Defects	
	Metabolic Disease
Blood/Bleeding Disorders	
	Musculoskeketal (Scoliosis, Cerebral Palsy, Muscular Dystrophy)
Cancer	
	Neurological Disease (Seizures, Speech, Vision, Hearing, Learning)
Cardiovascular Disorders (Hypertension, MI before 50, stroke)	
	Resp. Pulmonary Disease (Asthma, Cystic Fibrosis, TB)
Gastrointestinal (Colitis, Crohns disease, Ulcers, Irritable Bowel)	
	Skin Conditions

REVIEWED AND UPDATED PEDIATRIC HISTORY

Date	Signature	Date	Signature	Date	Signature