

Medical History for Child

Patient's Name: _____ Date of Birth: _____
 Race: _____ Ethnicity: _____
 Gender: _____

Pregnancy/Neonatal Period

Is the child yours by birth adoption surrogacy stepchild other _____
 If adopted: At what age? __ From what country? _____

This section only needs to be completed if the child is 1 year old or under:

Prenatal History (for the birth mother)

Did you have any complications with the pregnancy? NO YES _____
 Was conception or sustaining pregnancies a problem? NO YES _____
 Did you have any infections or illnesses during pregnancy? NO YES _____
 Did you have any abnormal prenatal labs or ultrasounds? NO YES _____
 Were you taking any prescription medicines? YES _____ NO
 Were their prenatal exposures to: Tobacco/Nicotine Alcohol other _____
 What vaccines did you receive during pregnancy: Flu DTaP RSV

Newborn/Infant Medical History

Was the child premature? No (37+ weeks) Yes, born at _____ weeks
 Birth weight: _____
 Did the baby go home on the same day as the mom? YES NO
 Any problems in the newborn period: NO YES _____
 Hearing screen in the hospital: Normal Needs further screening

Has your child ever been treated for or diagnosed with:

- Chronic poor feeding/growth concerns
- Eczema or chronic skin problems
- Recurrent wheezing
- Food allergy or intolerance
- Recurrent ear infections
- Cardiac concerns
- Pneumonia
- Urinary tract infection/Kidney problems
- Movement or developmental delays
- Other Chronic/recurrent medical conditions:

Hospitalized overnight in the hospital, other than at birth? _____
 Previous surgeries and dates: _____
 Previous Pediatrician, and date (or age) of last check up: _____
 Please list any specialist(s) your child is currently seeing and reason: _____

Medications

ALLERGIES to Medicines/ vaccines (list and describe reaction): _____

Current routine prescription medications and dose: _____

Routine over-the-counter medications: _____

Routine vitamins or supplements: _____

Family History

Do either of the child's parents or siblings (brothers or sisters) have:

Condition	Father	Mother	Siblings	Comment:
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Loss/deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke at age <55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes (type 1 or 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Celiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol or Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning difficulties/Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other genetically transmitted conditions that are important to know: _____

Social History:

Who lives in the child's home? Mom (s) Dad (s) Stepparent
 Siblings (#____) Grandparent(s) Other_____

Does your child live in multiple households? Yes No

Daytime care: At home Preschool/daycare Other_____

Smoke Exposure at home None Tobacco or Vape

Home water source: City Water Well Water Other? _____

Language(s) spoken at home English Spanish _____

Any special cultural or religious practices that are important for us to know about? _____