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 Ceserean
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):	_____	_____			
Menningitis:	_____				

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: