



Pediatric Medical History Form

www.pedsalex.com

Phone: (703) 924-2100 Fax: (703) 922-6067



Child's Name: _____ Birth Date: _____

DEMOGRAPHICS: Please list pertinent demographic information.

Name Age Occupation Highest Education Ethnicity

Mother _____

Father _____

Name Age Name Age

Sibling 1 Sibling 3

Sibling 2 Sibling 4

FAMILY HISTORY: Please indicate with a check (✓) the specified relatives with any of the following conditions:

Table with 13 columns (Medical Condition, Mom, Dad, Sister, Brother, Mom's Mom, Mom's Dad, Dad's Mom, Dad's Dad, Mom's Sister, Mom's Brother, Dad's Sister, Dad's Brother) and 30 rows of medical conditions.



Pediatric Medical History Form

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Child's Name: _____ Birth Date: _____

BIRTH HISTORY: Please fill in the blanks.

Hospital: _____ Type of Delivery: _____

Complications with Delivery: _____ Birth Weight (If known): ____ (lbs) ____ (oz)

Term: ____ (wks) Jaundice: (yes / no) Phototherapy: (yes / no)

CHRONIC MEDICATIONS: Please list the child's dose and frequency of chronic medications.

ALLERGIES: Please list any drug and/or food allergies, reaction if ingested, and date first noted.

PAST MEDICAL HISTORY: Please indicate any chronic conditions or problems of the child.

SURGERY: Please list any past surgeries and dates.

HOSPITALIZATION: Please list any past hospitalizations and dates.

SOCIAL HISTORY: Please answer the following questions.

Who lives in the household? _____

Are there any pets in the home? If yes, what kind? _____

Does anyone in the household smoke? _____

Are there any guns in the home? _____

If yes, outside or inside? _____

If yes, are they locked? _____

Are your child's parents married? If not, what is the custody arrangement? _____

Is your child in daycare? If so, what kind (in-home, group, babysitter, nanny)? _____

Lead risk: What year was your home/apartment built? _____

Languages spoken at home? _____

TB risk: Has the child traveled or lived outside of the U.S. for longer than 2 weeks? If so, what country? _____

Does your child visit the dentist every 6 months? _____