



Pediatric History Form

Date _____ Referred By _____
Patient Name _____ Phone Number _____
Address _____
City _____ State _____ Zip _____
Birth Date _____ Sex _____ Weight _____ Height _____ SS# _____
Names of Parents/Guardians _____
Purpose for contacting us? _____
Other doctors seen for this condition _____
Treatment _____

Check any of the following that pertains to your child:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Auto Accident | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures | <input type="checkbox"/> A Fall | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Traumatic Birth | <input type="checkbox"/> Adverse vaccination reaction |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Other _____ | | | |

Family History _____

Name of Pediatrician _____ Date of last visit _____

Reason _____ Treatment _____

Number of doses of antibiotics your child has taken:

- 1) In last 6 months: _____
- 2) Total during his/her life: _____

Number of doses of other prescription medications your child has taken:

- 1) During last 6 months: _____
- 2) Total during his/her life: _____

Vaccination history: _____

Feeding History:

Breast-fed If yes, how long? _____ Formula If yes, how long? _____

Introduced solids at _____ months. Cow's milk at _____ months.

Prenatal History:

Complications during pregnancy? Explain _____

Ultrasounds during pregnancy? How many? _____

Medications during pregnancy/delivery? List them _____

Cigarette/alcohol use during pregnancy? Frequency _____

Location of Birth Hospital Home Other _____

Birth intervention Forceps Vacuum Extraction C-section

Delivery complications? No Yes _____
Birth Weight _____ Birth Length _____ APGAR Scores _____

Childhood Diseases:

Chicken Pox Age: _____ Rubeola Age: _____ Whooping Cough Age: _____
 Rubella Age: _____ Mumps Age: _____ Other _____

Developmental History:

At what age was your child able to:

Respond to sound	_____	Crawl	_____
Respond to visual stimuli	_____	Stand Alone	_____
Hold head up	_____	Walk Alone	_____
Sit	_____		

Has your child ever been involved in a car accident? No Yes (List) _____

Has your child ever fallen? No Yes (List) _____

Prior surgery? No Yes (List) _____

I hereby authorize 100% to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed _____ Date _____

Relationship to Patient _____