Pediatric Health History Form

Please answer the following questions. If you are uncomfortable with any questions, you don't need to answer it. Your answers are NOT shared with anyone.

Child's Name: _____ Date of Birth: _____ M/F _____

Mother's Name: _____ Dad's Name: _____

Past History

Hospitalizations:_____ Infections: _____

Surgeries: (include Circumcision) _____

Chronic Disorders: _____ Accidents: _____

Allergies (Medication or foods) _____

Medications your child is on: (please include dosage) _____

Birth Hospital: _____ Birth weight: _____ Gestational Age: _____

Was NICU required: Yes/No If yes why: _____ How Long: _____

Delivery: ☐ Vaginal ☐ C- Section If C- Section Why: _____

Was initial feeding ☐ formula ☐ breast How long breastfed:_____

During pregnancy, did mom: Take Vitamins: YES/NO Take drugs or meds: YES/NO

Use Tobacco: YES/NO Alcohol Use: YES/NO

Were there any prenatal or neonatal problems: _____

Social History

Siblings: Name _____ Age: _____ M/F

Name: _____ Age: _____M/F

Name: _____ Age: _____ M/F

Living situation if not living with both biological parents: _____

Day Care: (type) _____ Special Diet: _____

Parents Highest Education: Mom: _____ Dad: _____

Child's Extracurricular activity: (Sports) _____

Always use seat belt or car seat: Y/N Smoking in the house: Y/N Working Smoke Detectors: Y/N

How would you describe your child's activity level: (older child) _____

(For older child) Alcohol Use: Y/N Drug Use: Y/N Sexual Activity: Y/N

Occupation of Mom: _____ Dad: _____

Preferred Pharmacy Name: _____ Address: _____

City or Zip: _____ Phone No: _____