Revised 01/08/2010

Pediatric History Form

Date _____ Date of last visit _____ Patient's Date of Birth _____

Chief Complaint _____

FAMILY HISTORY

- ❑ Tuberculosis
- ❑ Heart disease
- ❑ Sickle cell anemia
- ❑ Diabetes
- ❑ Seizures
- ❑ Mental retardation
- ❑ Allergies
- ❑ Asthma
- ❑ Smokers in home
- ❑ Other _____

BIRTH HISTORY (if under 3 years of age)

Mother's age at child's birth _____

Prenatal care _____

Medications/Drugs taken _____

Smoke/Drink during pregnancy _____

Length of gestation _____

Type of delivery _____

Complications _____

Birth weight _____

PAST HISTORY

Allergies to medications _____

Allergies (list all known) _____

Significant health problems/Hospitalizations _____

_____

Infections, Illnesses, Miscellaneous problems _____

❑ Chickenpox ❑ Frequent sore throats ❑ Frequent ear infections ❑ Frequent stomach aches

❑ Problems with teeth ❑ Other _____

Perceptual Patterns/Development

Hearing problems _____ Age walked _____

Eye problems _____ Age toilet trained _____

Speech (talks as much as other kids) _____ Child care _____

Social History

❑ Legal guardian Who lives in your household _____

❑ Foster parent _____

❑ Parent _____

Parent/Legal Representative name _____

Parent/Legal Representative Signature _____

Provider Signature _____ Date _____

Heart of Ohio Family Health Centers™

Pediatric Health History

NAME

DOB

MR #