



PEDIATRIC HEALTH HISTORY – 9+ Years



PLEASE ASK IF YOU NEED ASSISTANCE TO COMPLETE

Name of person completing form: _____ Relationship to patient: _____ Date: _____

ALLERGIES OF THE PATIENT

LIST ANY REACTIONS TO MEDICATIONS, FOOD, LATEX, DYE, ETC. 1. _____ 2. _____ 3. _____

MEDICATIONS OF THE PATIENT

LIST ALL CURRENT MEDICATIONS INCLUDING NON-PRESCRIPTION DRUGS, FLUORIDE, HERBS & SUPPLEMENTS	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
1.				3.		
2.				4.		

PRENATAL / BIRTH HISTORY

Any history of major prenatal/newborn problems for this child? No Yes: _____

Any history of major prenatal/newborn problems for brothers/sisters? . . . No Yes: _____

PATIENT & FAMILY MEDICAL HISTORY

Please check conditions that are applicable for each listed person

	Birth Date	Lives with Patient?	Allergy, Hay fever	Anemia	Asthma or frequent lung problems	Birth defects	Blood disease, bleeders	Cancer	Cholesterol problem	Convulsions or epilepsy	Deafness	Diabetes	Ear problems	Skin problem	Eye problems, not including glasses	Heart problems	High blood pressure	Kidney disease	Stomach or bowel disease	Mental/psychological/School problems	Sexually transmitted diseases (AIDS, Syphilis, etc.)	Substance Abuse	Other	
			Birth Mom's Name:		<input type="checkbox"/> Yes <input type="checkbox"/> No																			
Birth Dad's Name:		<input type="checkbox"/> Yes <input type="checkbox"/> No																						
LIST NAMES OF ALL CHILDREN (INCLUDING PATIENT) IN BIRTH ORDER	Child #1:		<input type="checkbox"/> Yes <input type="checkbox"/> No																					
	Child #2:		<input type="checkbox"/> Yes <input type="checkbox"/> No																					
	Child #3:		<input type="checkbox"/> Yes <input type="checkbox"/> No																					
	Child #4:		<input type="checkbox"/> Yes <input type="checkbox"/> No																					
	Child #5:		<input type="checkbox"/> Yes <input type="checkbox"/> No																					
	Child #6:		<input type="checkbox"/> Yes <input type="checkbox"/> No																					
Mom's Mom		<input type="checkbox"/> Yes <input type="checkbox"/> No																						
Mom's Dad		<input type="checkbox"/> Yes <input type="checkbox"/> No																						
Dad's Mom		<input type="checkbox"/> Yes <input type="checkbox"/> No																						
Dad's Dad		<input type="checkbox"/> Yes <input type="checkbox"/> No																						

ADDITIONAL MEDICAL PROBLEMS / PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

PLEASE FLIP PAGE TO COMPLETE

Patient Name: _____ DOB: _____

Date Completed: _____ Reviewed by: _____ MD / DO / ARNP / PA

