



Please fill out and return.

Pediatric Health History

Patient's Full Name: _____ Date: _____
Last, First, MI

Address: _____

Name of Parents: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Sex: M / F

Home Phone: _____

Other Healthcare Practitioners:

Name	Type of practice	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

List your current health concerns for your child, in order of their importance to you:

concern	date of onset
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Traumas, Car Accidents, Injuries

Surgeries and Hospitalizations

Date	Reason	Hospital
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Has your child ever had a blood transfusion? Y / N

Prenatal History

Did mother have any problems or illness during pregnancy? Y / N If yes
please describe:

Birth History: Vaginal / Cesarean / Forceps / Vacuum

Length of pregnancy: On time / Before 37 weeks / After 42 weeks

Any newborn problems? jaundice / hospitalization / other (describe)

Illness: Has your child had antibiotics? Y / N If so, how many rounds? _____

Vaccinations: Has your child had any vaccinations? Please list

Diet: Please describe your child's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks / Beverages: _____

