Pediatric Patient History and Health Assessment

Date:_____ **Patient Name:** _____ **DOB:**_____ **M / F**

MEDICATIONS: Please list all prescriptions and non-prescription medications, vitamins, birth control pills, herbs, inhalers, etc... Use the back of this form if you need more room and let us know that you wrote there.

☐ **NO MEDICATIONS**

Medication	Dose (mg)	How Many Times Per Day

ALLERGIES: Please list all allergies or intolerance to medications: Please include type of reaction:

☐ **NO KNOWN ALLERGIES**

Allergies/Medication	Type of Reaction

PROBLEMS WITH NEWBORN:

Jaundice?	YES / NO
Infections?	YES / NO
Colic?	YES / NO
Breathing Problems?	YES / NO
Feeding Problems?	YES / NO
Other	YES / NO

Significant Illnesses/Injuries:

_____

_____

_____

Has your child ever been hospitalized? If so please explain.

_____

_____

_____

CHILD'S MEDICAL HISTORY:

Eye Surgery	YES	/ NO	Date:
Glasses	YES	/ NO	Date:
Tonsillitis	YES	/ NO	Date:
Ear Infections	YES	/ NO	Date:
Ear Tubes	YES	/ NO	Date:
Frequent Colds	YES	/ NO	Date:
Asthma	YES	/ NO	Date:
Pneumonia	YES	/ NO	Date:
Heart Murmur	YES	/ NO	Date:
Chronic Skin Rashes	YES	/ NO	Date:
Chronic Constipation	YES	/ NO	Date:
Bedwetting over the age of 3	YES	/ NO	Date:
Seizure Disorder	YES	/ NO	Date:
Behavior Disorder	YES	/ NO	Date:
Learning Disorder	YES	/ NO	Date:
Other	YES	/ NO	Date:

Last well child check up? Date:_____

Are your child's immunization up to date? YES / NO

Are you able to provide a copy of your child's immunization record? YES / NO

Do you have any concerns regarding your child's health that you would like to discuss with the doctor? If so, please indicate:

_____

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date