Please fill out both sides of form

PEDIATRIC MEDICAL AND SOCIAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Parent/Guardian Name: _____ Person filling out form: _____

Current Medical Problem: _____

Allergies:	
Current Medications: (Please list prescriptions, over the counter drugs, vitamins, and herbal preps.)	
Past Medical History:	
Pregnancy: ☐ Normal ☐ Problem:	
Delivery: ☐ Normal Vaginal ☐ C-Section ☐ Problem:	
Birth Weight: _____ **Problem at or soon after birth:** ☐ No ☐ Yes:	
Hospitalization and Surgeries:	**Date:**

You and Your Family Medical History

	Child	Mother	Father	Brother	Sister	Other		Child	Mother	Father	Brother	Sister	Other
Alcohol / Drug Abuse							Musculoskeletal Disorders						
Allergies, nasal / eye							Nervous System Disorders						
Arthritis							Obesity						
Asthma							Osteoporosis						
Bleeding / Blood Disorder							Sickle Cell Anemia						
Cancer							Stroke / Blood Clot in Arm / Leg						
Depression							Thyroid Disease						
Diabetes							Tuberculosis						
Genetic Diseases / Birth Defects							Colitis						
Headaches / Migraines							Eye Disease						
Heart Problems (attack /angina)							Iron Deficient						
High Cholesterol							Liver Disease / Hepatitis						
High Blood Pressure							Psoriasis / Eczema						
Kidney Disease							Sudden, Unexplained Death						
Mental Illness / Suicide Attempt							Other:(describe)						

Please fill out both sides of form

PEDIATRIC MEDICAL AND SOCIAL HISTORY continued

Family Status:			
Relationship	**Name**	**Age**	**Comments**
Mother			
Father			
Sister(s)			
Brother(s)			
Step-Parent			
Half-Siblings			
Persons Living in Home with Child			

Environmental History: Do you have concerns about issues that may affect your child's health and safety? Check appropriate box(es) – write comments.

- ☐ Home Safety (chemicals, guns, etc.):_____
- ☐ Neighborhood Safety: _____
- ☐ Car, Bike Safety (seatbelts, helmet): _____
- ☐ Domestic Violence: _____
- ☐ Alcohol, Smoking, Drug use _____
- ☐ Stress: _____

Personal Concerns: Do you have concern(s) about your child's physical, mental, emotional, or social health? If yes check the appropriate boxes.

- ☐ Nutrition and Eating Habits:_____
- ☐ Sleep: # of Hours of Sleep in 24 hours: _____
- ☐ Physical Development: _____
- ☐ Weight: _____
- ☐ Behavior: _____
  - ☐ Relating to others: _____
  - ☐ Normal childhood play: _____
- ☐ Ability to Pay attention and perform routine tasks: _____

School-Aged Children:

- ☐ School Performance: _____
- ☐ Physical Activities: _____
- ☐ TV, Electronic Games: # of hours in 24 hours: _____

List your child's favorite activities (sports, arts, hobbies, etc.): _____

Other Comments:_____