PATIENT NAME _____
D.O.B. _____

San Diego Pediatrics

PEDIATRIC HISTORY FORM

When was your child's last physical exam? _____
Where? _____

BIRTH HISTORY

Yes No

☐ ☐ Did you receive prenatal care? Where?
Started care at _____ month.

☐ ☐ Was the baby full term? Birth weight?
Vaginal Delivery ☐ C-section ☐ Why? _____

☐ ☐ Did the baby go home with you from the hospital? If no, why not?
Hospital where the baby was born: _____

MEDICAL HISTORY

Yes No

☐ ☐ Has your child ever been hospitalized overnight or had any previous surgeries?
If yes, when, where, why? _____
_____
_____

☐ ☐ Is your child followed by a specialist
If so, for what condition? _____

☐ ☐ Does your child take any medications on a regular basis, including vitamins?
Please list: _____

☐ ☐ Is your child allergic to any medication? _____
What happens when your child takes this medicine? _____

☐ ☐ Are your child's shots up to date?

☐ ☐ Has your child ever had a reaction to an immunization?
What happened? _____

☐ ☐ Does your child have any food allergies? _____
What happens? _____

☐ ☐ Has your child ever had a positive TB test?
When? _____ Did he/she receive a chest x-ray? _____

☐ ☐ Has your child ever had any blood work or special tests done?

☐ ☐ Has your child ever had:
UTI? Date: _____/_____/_____ Medicine taken: _____
Asthma/Wheezing? Date: _____/_____/_____ Medicine taken: _____

☐ ☐ Does your child have frequent ear infections?

☐ ☐ Does your child have any medical problems? (Such as asthma, seasonal allergies, eczema, ADHD, seizures, etc.) _____

FOR FEMALE PATIENT'S ONLY

Yes No

☐ ☐ Have you started your periods? What age? _____

☐ ☐ Are they regular? They last _____ days
LMP: _____/_____/_____

☐ ☐ Cramps? Treatment for cramps _____

Comments: _____
_____

FAMILY MEDICAL HISTORY

	Has anyone in your child's family had any of these conditions?	Father	Paternal GF	Paternal GM	Mother	Maternal GF	Maternal GM	Brother	Sister	Paternal Aunt	Maternal Aunt	Paternal Uncle	Maternal Uncle	Other
1.	Alcohol Abuse													
2.	Anemia (V18.2)													
3.	Asthma (V17.5)													
4.	Autistic Disorder													
5.	Born with Congenital Abnormalities													
6.	Cancer													
7.	Cystic Fibrosis (V18.19)													
8.	Delayed Developmental Milestones													
9.	Depression													
10.	Diabetes Mellitus (V18.0)													
11.	Drug Dependence													
12.	Eczema													
13.	Heart Disease (V17.49)													
14.	Hepatitis													
15.	Hypercholesterolemia													
16.	Hypertension (V17.49)													
17.	Juvenile Rheumatoid Arthritis/ Autoimmune issues													
18.	Migraine Headache													
19.	No Significant Family History													
20.	Reported family history of Allergies													
21.	Reported family history of Bleeding Problems													
22.	Reported family history of Deafness before age 5													
23.	Reported family history of Early Sudden Deaths													
24.	Reported family history of Kidney Disease													
25.	Reported family history of Mental Illness (not retardation)													
26.	Seizure Disorder (V17.2)													
27.	Sudden Infant Death Syndrome													
28.	Thyroid Disorder (V18.19)													
29.	Tuberculosis													
30.	Gastrointestinal Issues (such as IBD)													

SOCIAL HISTORY

☐ Adopted ☐ Foster Child

Composition of Household – Brothers:

Name Child 1: _____ DOB: _____ Age: _____

Name Child 2: _____ DOB: _____ Age: _____

Composition of Household – Sisters:

Name Child 1: _____ DOB: _____ Age: _____

Name Child 2: _____ DOB: _____ Age: _____

Guns in Home? ☐ Yes ☐ No

Guardians are: ☐ Currently Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Single ☐ Other

Guardian's Occupation: _____ Guardian's Occupation: _____

Guardian's Signature _____ Date: _____/_____/_____