



PEDIATRIC HISTORY FORM

TODAYS DATE _____

Patient Name: _____ DOB: _____
 Primary Care Physician Name: _____ Phone: _____
 Other Treating Physician Name: _____ Phone: _____
 Pharmacy Name: _____ Phone: _____
 Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Reason for today's visit (New Patients ONLY) _____

Allergies: Please list any allergies your child may have to any medications .Please circle NONE if they do not have any known allergies.

NONE

Medications: Please list all the medications your child is currently taking, dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical History: Please list all surgeries. Include approximate dates, if possible.

Procedure: _____ Date: _____ Procedure: _____ Date: _____
 Procedure: _____ Date: _____ Procedure: _____ Date: _____

****If you are unable to fit all your procedures/surgeries in the above space, please utilize the back of the page****

Past Medical History: Does your child have or had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO	Kidney Disease	YES	NO	Heart Disease	YES	NO	
Asthma		YES	NO	Thyroid Disease	Hyper	Hypo	NO	Other	Yes	NO
High Blood Pressure		YES	NO	Cancer		YES	NO	If yes, please explain:		
Kidney Stones		YES	NO	If YES please specify:				_____		

When you were pregnant with this child: What was the length of pregnancy? _____

Was the pregnancy ? **NORMAL** **ABNORMAL** If abnormal, describe _____

IN-Vitro **YES** **NO**

If you had a pregnancy ultrasound, was it **NORMAL** **ABNORMAL**

Family History: Do you have a *family* history of any of the following?(grandparents, parents or siblings)

Diabetes	Type 1	Type 2	NO	Kidney Disease	YES	NO	Heart Disease	YES	NO	
Asthma		YES	NO	Thyroid Disease	Hyper	Hypo	NO	Bedwetting	YES	NO
High Blood Pressure		YES	NO	Cancer		YES	NO	Other	YES	NO
Kidney Stones		YES	NO	If YES please specify:			If yes, please explain:			
Bladder Anomolies		YES	NO				_____			
Genital Problems		YES	NO	Undescended Testis		YES	NO	_____		
Recurrent UTI's		YES	NO	Hernias		YES	NO	_____		

Review of Systems: Has your child ever experienced any of the following problems. **Please circle any that apply. If none apply, please circle NONE.**

Constitutional :	None	Fever	Chills	Headache	Other: _____	
Neurological :	None	Tremors	Numbness Tingling	Weakness	Other: _____	
Allergic/ Immunologic :	None	Seasonal Allergies	Drug Allergies	Other: _____		
Musculoskeletal :	None	Joint pain	Other: _____			
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other: _____		
Cardiovascular :	None	Heart Murmur	Other: _____			
Endocrine :	None	Excessive thirst	Other: _____			
Respiratory :	None	Wheezing	Shortness of breath	Frequent Cough	Other: _____	
Hematologic/ lymphatic :	None	Swollen Glands	Blood Clotting Problem	Other: _____		
Genitourinary :	None	Painful Urination	Urinary Frequency	Urinary Tract Infection	Blood in Urine	Other _____ _____ _____

Physician Reviewed/Date: _____ **Physician Reviewed/Date:** _____ **Physician Reviewed/Date:** _____

Patient Comments: Please comment on any issues/problems not covered in the above questions.

Patient Signature: _____ **Date:** _____