

## PEDIATRIC PATIENT HISTORY

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family History: Please let us know about your family's health. Please answer these questions as completely as you can.

**Please check the diseases that either Father or Mother have. For other relatives, circle F for Father's relatives and M for Mother's relatives.**

| Disease                               | Father | Mother | Grandmother | Grandfather | Patient's Brother/Sister(s) | Aunt | Uncle |
|---------------------------------------|--------|--------|-------------|-------------|-----------------------------|------|-------|
| ADD/ADHD                              |        |        | F M         | F M         |                             | F M  | F M   |
| Allergies                             |        |        | F M         | F M         |                             | F M  | F M   |
| Asthma                                |        |        | F M         | F M         |                             | F M  | F M   |
| Birth Defects                         |        |        | F M         | F M         |                             | F M  | F M   |
| Cancer                                |        |        | F M         | F M         |                             | F M  | F M   |
| Coronary Artery Disease               |        |        | F M         | F M         |                             | F M  | F M   |
| DDH (Hip Dysplasia)                   |        |        | F M         | F M         |                             | F M  | F M   |
| Deafness                              |        |        | F M         | F M         |                             | F M  | F M   |
| Depression                            |        |        | F M         | F M         |                             | F M  | F M   |
| Developmental Delay                   |        |        | F M         | F M         |                             | F M  | F M   |
| Diabetes                              |        |        | F M         | F M         |                             | F M  | F M   |
| Eczema                                |        |        | F M         | F M         |                             | F M  | F M   |
| Genetic Disorder                      |        |        | F M         | F M         |                             | F M  | F M   |
| Hemoglobinopathy (Sickle Cell)        |        |        | F M         | F M         |                             | F M  | F M   |
| High Cholesterol                      |        |        | F M         | F M         |                             | F M  | F M   |
| High Blood Pressure                   |        |        | F M         | F M         |                             | F M  | F M   |
| Learning Disability                   |        |        | F M         | F M         |                             | F M  | F M   |
| Mental Retardation                    |        |        | F M         | F M         |                             | F M  | F M   |
| Migraines                             |        |        | F M         | F M         |                             | F M  | F M   |
| Obesity                               |        |        | F M         | F M         |                             | F M  | F M   |
| Scoliosis                             |        |        | F M         | F M         |                             | F M  | F M   |
| Seizure Disorder                      |        |        | F M         | F M         |                             | F M  | F M   |
| SIDS (Sleeping Infant Death Syndrome) |        |        | F M         | F M         |                             | F M  | F M   |
| Strabismus                            |        |        | F M         | F M         |                             | F M  | F M   |
| Thyroid Disease                       |        |        | F M         | F M         |                             | F M  | F M   |
| Other: _____                          |        |        | F M         | F M         |                             | F M  | F M   |

List any Chronic Illness your child has, if any:

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List any Surgeries your child has had with the dates of those surgeries:

| Type of Surgery | Date of Surgery |
|-----------------|-----------------|
| _____           | _____           |
| _____           | _____           |
| _____           | _____           |

List any Daily Medications your child takes:

| Medication Name | Dose  | How Many Times A Day |
|-----------------|-------|----------------------|
| _____           | _____ | _____                |
| _____           | _____ | _____                |
| _____           | _____ | _____                |

Is your child allergic to any medications:  Yes  No If Yes, please list the medicine and reaction your child has:

| Medication Name | Allergic Reaction |
|-----------------|-------------------|
| _____           | _____             |
| _____           | _____             |
| _____           | _____             |