PEDIATRIC HEALTH HISTORY
(Birth through 17)

Date: ____________________ Chart # ____________________

Name: ____ DOB: ____________________

BIRTH HISTORY: (Complete only if child is under 2)

Prenatal complications:

Birth weight ____________ Full term: ________ Premature: ____________ Wks
Delivery: Vaginal ________ C-section ________ Complications: ____________
Post Partum Complications: ______________________________

PAST MEDICAL HISTORY: (Please include dates and hospitals, if known)

Hospitalizations/operations:
____

Major Illnesses: ______________________________

Current Medications: ______________________________

Allergies: (medications, food, other) ______________________________

HABITS:

Tobacco Use	________ No	________ Yes,	Daily Amount ________
Alcohol Use	________ No	________ Yes,	Daily Amount ________
Exercise	________ No	________ Yes,	Daily Amount ________

FAMILY HISTORY:

	Significant Medical Problems	Cause of Death (if applicable)
Father	______________________________	____________
Mother	______________________________	____________
Brothers	______________________________	____________
Sisters	______________________________	____________

IMMUNIZATIONS: (include dates, if known)

Hepatitis B	______	______	______		
DPT	______	______	______	______	______
Tetanus Booster	______				
Polio	______	______	______	______	
Hib	______	______	______	______	
Measles/Mumps/Rubella	______	______			
Pneumovax	______				

PLEASE USE BACK OF FORM FOR ADDITIONAL INFORMATION