The Pediatric Center

Medical History

Name of Child: _____ **D.O.B.** _____

Allergies (food, drugs or environment)	Date of onset	Type of reaction
1.		
2.		
3.		

Current Medications:

Name	Dose	Frequency
1.		
2.		
3.		

Major Medical problems (Hospitalizations, Surgeries, etc.)

1. _____
2. _____
3. _____

Family History

On either side of the family, could you let us know if these conditions are present, and who has them? lfthe history is unknown, write a "U" next to the items. lfyou are unsure, put a"?".

Condition	Who Mi!!ht Have It
Early Heart Disease (Sudden death, heart attack <55yo)	
Elevated Cholesterol	
Elevated Blood Pressure	
Lung Problems (asthma, tuberculosis)	
Allergies (drugs, food or seasonal)	
Liver problems (hepatitis, cirrhosis)	
Blood disorders (anemia, excessive bleeding, low platelet)	
Kidney problems (stones, failure)	
Digestive problems (colitis, ulcers,' gastritis, celiac)	
Neurological problems (seizures, migraines)	
Thyroid gland problems	
Diabetes (adult or juvenile)	
Obesity	
Emotional difficulties (depression, anxiety, OCD, panic)	
Cancers	
Congenital defects	
Learning difficulties (ADD, PDD, Autism)	
Substance use (alcohol, prescription or street drugs)	

Social History

Who lives at home: (please include all)
Do you live in (circle): Apartment Condo House Other (please specify)
List any pets:
Do you have well water or town water:
Does anyone in the home use tobacco:

Completed by: _____ Date: _____