

**Becker Family Medicine, SC**

***Pediatric Health History Form***

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health Problems: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health Problems: \_\_\_\_\_

Sibling(s) Name & Age:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Patient current medical problem(s):

\_\_\_\_\_ Date Began: \_\_\_\_\_  
\_\_\_\_\_ Date Began: \_\_\_\_\_  
\_\_\_\_\_ Date Began: \_\_\_\_\_

Current Medications:

\_\_\_\_\_  
\_\_\_\_\_

Serious Illness, Injury, Hospitalizations:

Year                      Type of Illness, Injury, Surgery  
\_\_\_\_\_  
\_\_\_\_\_

List any know drug allergies/reaction:

\_\_\_\_\_

Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Gestation Age of Delivery: Early <38 wks    Term 38-42 wks    Late > 42 wks

Did your child go home from the hospital with you?    Yes    No    Why not:

\_\_\_\_\_

Prenatal Complications:

\_\_\_\_\_

Was your baby:    Jaundiced    -    Yes / No            Breast fed / Formula fed    How long? \_\_\_\_\_

Has your child ever had wheezing or bronchitis?                      Yes                      No

Has you child ever had chicken pox?                                      Yes                      No

Date/Age: \_\_\_\_\_

Do you have questions concerning the insertion of your car safety seat?                      Yes                      No

Do you have the phone number to poison control?                      Yes                      No

Do you wish to learn CPR?    Yes                      No

Do you have any questions to discuss with the provider?                      Yes                      No

Please identify health problems in the patient or blood relatives:

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<u>Condition</u>	<u>Patient/Relative</u>	<u>Condition</u>	<u>Patient/Relative</u>
Alcohol/Drug Addiction	_____	Genetic Disorders	_____
Allergies	_____	Heart Disease	_____
Anemia/Blood Disorders	_____	HIV/AIDS	_____
Asthma	_____	Kidney Disease	_____
Bed Wetting Issues	_____	Behavior Problems	_____
Lung Disease	_____	Birth Defects	_____
Mental Illness	_____	Retardation	_____
Bone/Joint Disease	_____	Muscle Disorders	_____
Cancer	_____	Rheumatic Fever	_____
Chronic Diseases	_____	Rheumatoid Arthritis	_____
Diabetes	_____	Seizures/Epilepsy	_____
Digestive Disorders	_____	Thyroid Disorders	_____
Eye/Ear Disorders	_____	Tuberculosis	_____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary healthcare services my child may need.

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by provider: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Comments:  
\_\_\_\_\_