

Harnett Health

Pediatric Medical History

Patient's Name _____ Date of birth ____/____/____
(First) (Middle) (Last)

Person Completing this Form: _____ Relationship _____

Please list any medical problems, past and present, that your child has been treated for by a medical provider (asthma, allergies, congenital malformations, diabetes, etc.)

BIRTH HISTORY:

List any pregnancy complications (pre-eclampsia, maternal diabetes, premature delivery, etc):

Was child delivered term (40 weeks) _____ If not, how many weeks old when born? _____

Birth weight ____ lbs ____ ounces

List any complications after child was born, up to about 2 weeks of age : _____

MEDICAL CARE:

Please list any SURGERIES and approximate dates:

Please list any HOSPITALIZATIONS and approximate dates:

Please list any CURRENT MEDICATIONS and approximate dates:

Immunizations: Up to date Not up to date Not immunized Unsure

List the medical office(s) who have administered your child's vaccines:

Drug Allergies:

HOME/SOCIAL ENVIRONMENT:

Who lives in the home with your child?

Name _____

Relationship _____ Age _____

Marital status of parents:

- Married
 Divorced
 Separated
 Never Married

Does anyone smoke around the child? _____ If yes, who? _____

Are there any guns in the home? _____ If yes, are they locked up? _____

SCHOOL:

- Public
 Private
 Home Schooled

For public or private school, please provide name of school: _____

Grade level: _____

School performance: Above Average Average Below Average

Discipline Problems? YES NO

NUTRITION:

Please list any food allergies or diet restrictions your child has:

Do you feel your child eats healthy? _____ If no, what are your concerns? _____

Do you feel your child is overweight? _____

ACTIVITY:

List school and non-school related sports and physical activities in which your child actively participates:

Please list the number of hours per day your child spends doing the following activities:

Playing sports/Physical activity	_____	Doing Homework	_____
Sleeping	_____	Watching TV:	_____
Playing video games:	_____	Computer/Internet:	_____

FAMILY HISTORY:

Please list illnesses, if known, pertaining to relatives listed below.

If child is adopted or family medical history is unknown, please check here:

Mother: Alive Deceased: [please list age when she died: _____]

Medical problems, if any:

Father: Alive Deceased: [please list age when he died: _____]

Medical problems, if any:

Brothers: How many? _____ Current ages? _____

Medical problems, if any:

Sisters: How many? _____ Current ages? _____

Medical problems, if any:

List any major medical problems that grandparents or aunts/uncles have, especially relating to heart disease, diabetes, stroke, cancers, etc.)
