Harnett Health
Premiere Pediatrics

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_____

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

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.)

_____

_____

_____