

New Pediatric Medical History

Name _____
 Date of Birth _____
 Date of Visit _____
 Reason For Visit _____



Inspired by the Patients We Serve

Please have your vaccine/shot record ready for staff

Past Medical History

| Have you ever had any of the following? | No | Yes | Describe the problem: Dates: Medication; Hospitals; Results | For Medical Team Only |
|--|----|-----|---|-----------------------|
| 1. Birth History: PLEASE CIRCLE C-Section or Vaginal Delivery Hospital _____ NICU stay: Yes or No Preterm or Term Gestational weeks @ delivery _____ Birth weight _____ Pregnancy issues such as diabetes, high blood pressure, preeclampsia, depression, other _____ _____ _____ | D | D | | |
| 2. Medical Problems (asthma, high blood pressure, others) | D | D | | |
| 3. List any Medications taken regularly | | | | |
| 4. List any allergies to medications and describe | D | D | | |
| 5. Any hospitalizations – when, where, and why | D | D | | |
| 6. Specialist seen – when, where, and why | D | D | | |
| 7. Attention Deficit Hyperactivity Disorder (ADHD) | D | D | | |
| 8. Developmental or Learning Delays | D | D | | |
| 9. Needed PT/OT/Speech therapy? | D | D | | |
| 10. Ever smoked cigarettes, electronic cigarettes | D | D | | |
| 11. Ever used alcohol or drugs | D | D | | |
| 12. If female, are you or could you be pregnant? | D | D | | |
| 13. If female, please give the first date of your last period. | D | D | | |
| 14. If female, any problems with your periods? | D | D | | |

Other Comments for the Provider:

