New Pediatric Medical History

Name _____

Date of Birth _____

Date of Visit _____

Reason For Visit _____

_____

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:

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