Bennett Family Medicine
Pediatric History Form

Name: _____ Today's Date:_____
(first) (middle) (last)
Age: _____ Birth Date: _____ Male or Female (circle one)

Mother: Full Name _____
Birthdate _____
Contact Phone # _____

Father: Full Name _____
Birthdate _____
Contact Phone # _____

List all persons who live in the child's home

	Name	Relation	Age
1)			
2)			
3)			
4)			

Allergies

	Name	Dose	How Often	Start Date
1)				
2)				
3)				

Medications (including over the counter)

	Type	Special Instructions
1)		
2)		
3)		

Birth History

During pregnancy, did the <u>mother</u> have any of the following:

Condition	Y or N	Notes
High Blood Pressure		
Bleeding		
Diabetes		
Preterm Labor		
Infections		
Smoking		
Alcohol or Drug Use		
Sexually Transmitted Diseases		
Other:		
Other:		

Hospitalizations & Surgeries

	Date	Reason
1)		
2)		
3)		

1) Did the mother have a cesarean section? Y or N
2) Did the child have any problems requiring extended treatment in nursery? Y or N
3) Was the child born: on-time early late (circle one)
4) What was the child's birth weight? _____lbs _____oz
5) Did the mother have any complications during or after labor? Y or N
Preferred Pharmacy_____

Has your child or any family members (including parents, grandparents, aunts, uncles, sisters or brothers) had the following:

Condition	Family	Child	Notes	Condition	Family	Child	Notes
Allergies				Lung Disease			
Asthma				Seizures			
Visual Problems				Stomach Problems			
Ear Infections				Bowel Problems			
Hearing Loss				Psychiatric Problems			
Throat Infections				Kidney Disease			
Heart Defects				Liver Disease			
Diabetes				Attention Deficit Disorder			
Thyroid/Hormone Problems				Learning Disability			
Easy Bruising/Bleeding				Genetic Diseases			
Muscle Weakness Disease				Cancer			
Cystic Fibrosis				Other:			

Is the home tobacco free? Y or N
Does your child wear a bike helmet while riding? Y or N
Is your child in school or day care? Y or N
Are there smoke detectors in the home? Y or N
Seat belts used in the car? Y or N

Do you have a pool? Y or N
Are there guns in your home? Y or N

Immunizations

Are your child's immunizations up to date? Y or N
Unsure? Y or N