PARTNERS IN HEALTH

Pediatric/Adolescent Medical History

Date of Visit ____/____/_

Child's Full Name	DOB ___/___/___	Nickname	Home Phone
Father	Age	Occupation	Work Phone
Mother	Age	Occupation	Work Phone
Stepparent/Guardian	Age	Occupation	Work Phone

Primary Language in Home:	Daytime Caretaker: ☐ Day Care Center ☐ After School Care ☐ School ☐ Baby-sitter ☐ Relative ☐ None	Telephone Number of Caretaker: 1. _____ 2.

HOUSEHOLD MEMBERS:

Does anyone living with you have a chronic medical problem? ☐ Yes ☐ No

Name	Age	Relationship	Name	Age	Relationship
Name	Age	Relationship	Name	Age	Relationship
Name	Age	Relationship	Name	Age	Relationship

CHILD'S HEALTH HISTORY:

Birth Weight: _____

Is child adopted:	☐ Yes	☐ No
Any complications with pregnancy?	☐ Yes	☐ No
Any complications effecting the baby before, during or right after delivery?	☐ Yes	☐ No
Has your child missed any regular shots or vaccines?	☐ Yes	☐ No

OPERATIONS AND HOSPITALIZATIONS:

Has the child had any operations?	☐ Yes	☐ No
Has the child ever been hospitalized	☐ Yes	☐ No

If yes to either question, please list: _____

_____

OTHER CONDITIONS OR CONCERNS:

Has your child had trouble with recurrent illness?	☐ Yes	☐ No
Is your child taking any medications?	☐ Yes	☐ No
Do you have any questions about the development of your child?	☐ Yes	☐ No
Does your child have any hearing or vision problems or other disabilities?	☐ Yes	☐ No
Has your child had any problems with shots/ vaccinations?	☐ Yes	☐ No
Is your child allergic to foods, drugs, or other materials?	☐ Yes	☐ No

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(OVER PLEASE)