Pediatric General History Form

Name:		Date:	
Date of Birth:		Age:	Gender: □ Male □ Female

Active Problems:		
Past Major Medical Problems & Hospitalizations:		
Surgeries:		
Medications, herbs, and supplements used:		
Allergies: (to medicine, environment, food and other)		
Birth & Development	**Full Term:** □ Yes □ No	**Birth Weight:**
Delivery: □ Vaginal □ C-section	**Birth Complications:**	
Pregnancy issues (meds, alcohol, smoking, other):		

Family History	Age at death	Check if they have: Heart disease	Stroke	Diabetes	Asthma	Cancer	Other medical conditions (for example, ADHD, Anemia, Autism, Bipolar, Cerebral Palsy, Depression, Bleeding Problems, Down Syndrome, Headaches, High Blood Pressure, High Cholesterol, Kidney Problems, Liver Disease, Seizures, Thyroid)
Father							
Mother							
Brother							
Sister							

Social History					
Tobacco Smoke Exposure at Home? □ Yes □ No					
Daycare/School & grade:					
Siblings – how many?					
Pets – what kind?	□ cats	□ dogs	□ birds	□ fish	□ rabbits
	□ gerbil, hamster, guinea pig		□ reptiles - turtles, lizards, snakes		□ frogs

*** Please bring your immunization records to office visit, thank you ***