Health Ministries Clinic
COMMUNITY HEALTH CENTER

Pediatric History Form

Patient Name:_____ DOB:____/____/_____
Today's Date:_____/_____/_____

Medical History

How old was the mother when the patient was born? _____

Which pregnancy was this child for the mother?_____

Did the mother use any of these substances during pregnancy?

- ☐ Alcohol—How much? _____
- ☐ Illegal Drugs—What? _____
- ☐ Smoking—How much? _____

Was this child born full term? _____ If no, how early/late? _____

How much did the child weigh at birth?_____

Was the child healthy at birth?_____

Has the child ever been hospitalized?

Age of Child	Cause of hospitalization
_____	_____
_____	_____
_____	_____
_____	_____

Has the child ever had surgery?_____

Age of child	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: ☐ **Yes** ☐ **No**

List all reactions to medicine, foods and other agents.

Allergy	Reaction or Side Effect

Does this child use any medications on a routine basis?

Medication	Dose/Frequency	Reason

Does this child have any history of the following?

- ☐ Allergies
- ☐ Asthma
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Seizures
- ☐ Eczema - Atopic Dermatitis
- ☐ Recurrent Ear Infections
- ☐ Other (specify) _____

Immunizations:

Are Immunizations up to date? _____ **Please supply a copy of record.**

Development:
Do you have any concerns about your child's development?
_____
_____

If school age: Grade _____
School _____

Social History:
Please list all persons who live with the child

Name	Age	Relationship to the child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any pets in the home? _____
How many? _____ What? _____

Are there any smokers in the home? _____
Smoke outside only? _____

Family History:

Do any of the child's family members (parent, sibling) have any of the following?

- ☐ Allergies _____
- ☐ Asthma
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Birth Defects
- ☐ Mental Retardation
- ☐ Death before age 21 _____ Cause _____
- ☐ Eczema - Atopic Dermatitis
- ☐ Seizures
- ☐ Other (specify) _____

What concerns would you like to discuss with the doctor today? _____
_____
_____
_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or clinic staff responsible for any errors or omissions that I may have made in completing it.

_____ _____
Signature of Parent or Guardian Date

This area is to ***only*** be filled out by a *Health Ministries Staff member*, if patient needed help filling out this form and patient or patient's legal representative is present.

_____ _____ _____
HMC Staff Name (PRINT) HMC Staff Signature Date