Health Ministries Clinic
COMMUNITY HEALTH CENTER

PEDIATRIC HEALTH HISTORY

Patient Name: _____
Last Name First Name Middle Initial

DOB: ____/____/_____

Date: ____/____/_____

Medical History

How old was the mother when the child 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? ☐ Yes ☐ No, how early/late? _____

How much did the child weigh at birth?_____

Was the child healthy at birth? ☐ Yes ☐ No, specify: _____

Has the child ever been hospitalized?

Age of Child	Reason of hospitalization
_____	_____
_____	_____
_____	_____

Has the child ever had surgery?

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

Does this child have any history of the following?

☐ Allergies ☐ Seizures ☐ Other: _____

☐ Asthma ☐ Eczema - Atopic Dermatitis

☐ ADD/ADHD ☐ Recurrent Ear Infections ☐ Other: _____

List all reactions to medicine, foods and other agents. ☐ N/A

Allergy	Reaction	Side Effect

Does this child use any medications on a routine basis? ☐ Yes ☐ No

Medication	Dose/Frequency	Reason

Immunizations:

Are Immunizations up to date? ☐ **Yes** ☐ **No,** specify: _____ **Please provide a copy of the 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? ☐ Yes ☐No

How many?_____What kind of pet(s)? _____

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
- ☐ ADD/ADHD
- ☐ Birth Defects
- ☐ Mental Retardation
- ☐ Death before age 21; Age ____ 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 Patient or Guardian Date

_____ _____
Print name of Patient or Guardian Relationship

HMC OFFICE USE ONLY

This section is to be filled out by HMC staff. IF, the above patient needed help filling out this form and the patient and/or legal representative is present.

Staff Name: _____ Date Completed: ____/____/_____