



Pediatric Health Database

Name _____

Today's Date ___ / ___ / _____

Parent(s)/Guardian _____

Date of Birth ___ / ___ / _____

Birth History

Sex of child ___ Child is # ___ of ___ children

___ Vaginal delivery ___ C-section (reason: _____)

___ Full term ___ Pre-term

Complications _____

___ Breast fed ___ bottle fed (formula: _____)

Medical/Surgical History

List any medical problems or surgeries child has had in the past

Social History

Smoker(s) in home? ___ yes ___ no

Pets in home? ___ yes ___ no

Gun in home? ___ yes ___ no

Pool at home? ___ yes ___ no

Family religious/spiritual preference? _____

Medications

List any medications child has taken in last year (include over-the-counter and herbal medicines)

Allergic or sensitivity reactions to any medication, product, or food

None ___ List _____

Family History

Family Member	Health Problems	Cause of Death
Father		
Mother		
Brothers		
Sisters		
Children		
Grandparents		

Is there any history of sudden unexplained death in your family? _____

Names of other family members seen in our office _____