Pediatric Care Corner, P.C. **Health History (Page 1)**

Patient Name: _____, _____ _____ Date of Birth: _____ / _____ / _____
Last *First* *Middle* *MM* *DD* *YYYY*

Birth History

Hospital: _____ Obstetrician: _____

Type of delivery: Vaginal or C/Section Birth Weight: _____ Days in the hospital: _____

Did you or your baby have any complications with the pregnancy, delivery, or immediately post-partum? Please explain below.

Developmental History

At what age did your child:

Coo / laugh: _____ Sit up: _____ First words: _____ Walk: _____ Toilet-training: _____

Health History

Child's last physician: _____ City, State: _____

Approximate date of last well child exam: _____

Does your child have any medical problems? Please explain below.

Does your child see any other doctors (e.g. specialists, podiatrists, chiropractors, etc.) regularly? If so, please list below.

Has your child ever been hospitalized overnight (not including ER visits) or had any surgeries (either inpatient or outpatient)? If so, please list all hospitalizations and surgeries below.

Date / Age	Hospital	Reason for admission / surgery

Does your child take any medications (including fluoride and over-the-counter medicine) regularly? If so, please list below.

Is your child allergic to any medicines or foods? If so, please list.

Pediatric Care Corner, P.C. **Health History (Page 2)**

Patient Name: _____, _____ _____ Date of Birth: _____ / _____ / _____
Last *First* *Middle* *MM* *DD* *YYYY*

Immunization History

Does your child receive all required immunizations? If no, please explain.

Has your child had a serious (e.g. very high fever, very fussy, etc.) reaction to immunizations? If yes, please explain.

Review of Systems

Has your child had problems with any of the following? (Please circle if yes)

AIDS/HIV	Chicken pox	Heart problems	Rheumatic fever
Anemia	Constipation / diarrhea	Hepatitis	Sinus problems
Asthma	Convulsions / seizures	Kidney disease	Speech problems
Bed wetting	Diabetes	Lead poisoning	Thyroid disease
Birth defects	Drug / Alcohol abuse	Liver disease	Tuberculosis / TB
Bladder problems	Ear infections	Measles	Urinary diseases / infection
Bleeding (excessive)	Epilepsy	Mononucleosis	Vision problems
Cancer	Fainting	Mumps	Worms
Cerebral palsy	Hearing problems	Pneumonia	Other (please specify)

Family History

Has any family member or close relative had problems with the following? (Please circle if yes and indicate the family member)

Condition	Relationship	Condition	Relationship	Condition	Relationship
Arthritis (juvenile)		Diabetes		Mental disorders	
Asthma/hay fever		Heart disease		Migraine	
Cancer		Hemophilia (bleeding)		Tuberculosis / TB	
Chemical (drug/alcohol) abuse		High blood pressure		Other (please specify)	
Convulsions/seizures		Kidney disease			

Parent's signature: _____ Date: _____

Physician's signature: _____ Date: _____