THOMASON MEDICAL CLINIC

PEDIATRIC HEALTH HISTORY DATE_____

Demographics & Allergies

Patient Name: _____
Birth Date: _____
Drug allergies:
_____
_____
_____

Newborn History

Birth Weight: _____
Birth Length: _____
Delivered: ☐ Vaginal ☐ C-Section
☐ Term ☐ Premature

Illness or Complication: -
_____
_____

Environmental History

With whom does the child live? ☐ Parent(s) ☐ Other
Does this child attend daycare
or a Mother's Day Out Program? ☐ Yes ☐ No

Are there pets in the house? ☐ Yes ☐ No
Kind(s): _____

Does anyone in the house smoke or
chew tobacco, drink alcohol/use drugs? ☐ Yes ☐ No

Has the child developed allergies? ☐ Yes ☐ No
List_____
_____

Family History

Mother: _____
Father_____

	Name	Sex	Age
Siblings	1._____		
	2._____		
	3._____		
	4._____		
	5._____		

Physician Signature

Family Disease

Please indicate which family members are affected.

- ☐ Asthma _____
- ☐ Blood/Bleeding Disorder_____
- ☐ Cancer_____
- ☐ Diabetes _____
- ☐ Renal_____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Mental Illness_____
- ☐ Sudden Unexpected Death _____

Past Hospitalizations, Surgeries, Fractures

_____
_____
_____
_____
_____

Immunization Status

_____
_____
_____
_____
_____

Health Status

_____
_____
_____
_____

Chronic Illness

_____
_____
_____
_____

Daily Medication

_____
_____
_____
_____

Date