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Pediatric Medical History Record

Name: _____

Birthday: _____

Birth History

Weeks Gestation: _____ Type of Delivery: _____ Date of discharge: _____
Birth Weight: _____ Discharge Weight: _____ Length: _____
Hospital: _____ Obstetrician: _____ Breast / Bottle Fed (circle)
Pregnancy/Delivery/Nursery Problems: _____
_____

Medical History of Child

Chronic Illnesses: _____
Hospitalizations (reason/age): _____
Surgeries (age/type): _____
Allergies: _____ Reaction: _____
Medications (dosages): _____
Developmental Problems: _____

Family History (indicate who has/had each illness)

Asthma: _____ Allergies: _____
Heart Disease: _____ High Blood Pressure: _____
High Cholesterol: _____ Diabetes (adult/youth onset): _____
Genetic Disorders: _____ Behavioral/Psychiatric Disorders: _____
Unexpected Death (infants, others< 45yrs): _____ Cancer (type): _____
Blood Disorders: _____ Neurological disorders: _____
Endocrine Disorders (i.e. thyroid): _____ Kidney Diseases: _____
Stomach/Intestinal Disorders: _____ Other: _____