Happy & Healthy Pediatrics

Pediatric, Adolescent, & Breastfeeding Medicine

Patient Name: _____

Patient DOB: _____

Pediatric Patient History Form

Social History

Parents:	**Married**	**Divorced**	**Separated**	**Single**	**Adopted**		
Siblings - Please List:							
How many people live in your home?		**Adults**			**Children**		

Any Changes in Address/Phone?	**Yes**	**No**	**Are you receiving our Text/E-mail Communications?**	**Yes**	**No**
Does your child drink caffeine?	**Yes**	**No**	**Are there any smokers at home?**	**Yes**	**No**
Is there a swimming pool at home?	**Yes**	**No**	**Are guns kept in the home?**	**Yes**	**No**
Are there smoke detectors at home?	**Yes**	**No**	**Are there Carbon Monoxide detectors in the home?**	**Yes**	**No**
Do all family members use Seat Belts/car safety sets?	**Yes**	**No**	**Do all family members use helmets when biking?**	**Yes**	**No**
Are there pets at home? (If so, please list):					
Any issues we should be aware of:					

Medical History

Within the past year have there been any:

Hospitalizations	**Yes**	**No**	**Why/Where:**
Urgent Care Vsits	**Yes**	**No**	**Why/Where:**
Emergency Room Visits	**Yes**	**No**	**Why/Where:**
Surgeries	**Yes**	**No**	**Why/Where:**
Specialist Visits	**Yes**	**No**	**Why/Where:**

Please list any:

Current Medications	**Yes**	**No**	**Please list:**
Allergies	**Yes**	**No**	**Please list:**
Other Concerns	**Yes**	**No**	**Please list:**

Family Medical History						
	Child's Father	Child's Mother	Sibling	Sibling	Grandparent	Other
Year of Birth (If Known)						
Year of Death (If Known)						
Cause of Death (If Known)						
Heart Problems						
Sudden Cardiac Arrest (Death)						
High Blood Pressure						
Stroke						
High Cholesterol or Triglycerides						
Cancer (Type)						
Bleeding Problems						
Anemia						
Genetic Syndrome						
Diabetes (note if onset as Adult or Child)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Gastrointestional Disease						
Kidney Disease or UTI						
Migraines						
Seizures						
Autoimmune Disease						
Allergies (food, medication, seasonal etc.)						
Psychiatric Problems						
Developmental Problems						
Autism						
Depression/Anxiety						
Eating Disorder						
Drug Abuse						
Alchohol Abuse						
Other:						

Patient/Parent/Representative Signature: _____ **Date:** _____

Patient/Parent/Representative Print: _____ **Relationship to Patient:** _____

MD Reviewed: _____