Pediatric Medical History Questionnaire

Appointment Date/Time ____________

Patient's Name ______________________________________ Birth Date _______________ Sex ______

Previous Physician ___________________________ Pharmacy _________________________________

Are you taking any medications, pills, or supplements? Yes No (Please list) ____________________

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Are you allergic to any medication or latex? Yes No (Please list) _____________________________

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Please indicate if you have had any of the following

Acne	Concussion	Heart Murmur	Any other (Please list)
ADD/ADHD	Congenital heart disease	Otitis media, recurrent	____________________
Allergic rhinitis	Constipation	Pneumonia	____________________
Anemia	Diabetes (type) ____________	Prematurity	____________________
Asthma	Eczema	Pyelonephritis	____________________
Birth trauma	Fracture	Seizure disorder	____________________
Bleeding disorder	GERD	Urinary tract infection	____________________
Bronchitis/bronchiolitis	Headache/Migraine headache	Vesicoureteral reflux	____________________
Bleeding Problems	Glaucoma/eye disorder	Stroke	____________________
Cancer	Headache/Migraines	Thyroid Disease ____________________	

Have you had any surgeries? Yes No (please list-include year, physician and what was done)

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Family History (Please list any conditions that run in your biological family-even if they are deceased or alive and well)

	Father/Mother/Child Grandfather/Grandmother Sister/Brother		Father/Mother/Child Grandfather/Grandmother Sister/Brother
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