Jupiter Family Medicine

Pediatric Health History

Child's Name_____ **DOB** _____
Mother's Name_____
Father's Name_____
Child lives with_____

Prenatal/Birth History:

Delivery □ vaginal □ C-section
Birth Weight_____
Did your child have any problems right after birth? _____
_____
Did your child have any problems as a young infant? _____
_____

Family History:

Have any members of your child's immediate family had any of the following? If yes, please indicate which family member.

Drug/alcohol problem _____
Allergies/Asthma _____
Diabetes _____
Emotional Illness _____
Kidney Disease _____
Mental Retardation _____
Sickle Cell _____
Anemia _____
Birth Defects _____
High Cholesterol _____
Heart Disease _____
Cancer _____
Seizures _____
Tuberculosis _____
Other _____

Hopitalization/ Surgeries/ Serious Illness: _____
_____
_____
Allergies to Medications? _____
Allergies to foods? _____
Current medications _____
_____
Does your child see any other health care providers/Therapists? _____
_____

Parent/Guardian Signature _____ **Date** _____