Charis Family Clinic PEDIATRIC Medical History Information

(age 17 and younger)

Patient's Name ____ Date of Birth _____________ Age _______

Address ____ City _______________ State ________ Zip ________

Sex: ______Male ______Female

Pharmacy Name _______________________________________ Pharmacy #(_____)_________________________

BIRTH HISTORY (PATIENT'S)

If premature, number of weeks gestation when born:_______________

Type of Birth: ____ Vaginal ____ C-Section Birth weight ______________

Complications during pregnancy or birth? ______ If yes, explain: ____

PAST MEDICAL HISTORY

Do you have concerns about your child's general health? ___ No ___ Yes
If yes, please specify: ____
Is your child allergic to any medications? ______No _____Yes, which ones (list REACTION also)? __________________
_________________ ____

Does your child have a history of:

☐ Anemia
☐ Asthma
☐ Attention Deficity/Hyperactivity
☐ Behavior Problem (type _______)
☐ Bleeding Disorders
☐ Ear Infections
☐ Cancer (type ___________)
☐ Diabetes
☐ Kidney Disease
☐ Growth Problem
☐ HIV
☐ Infections (type _____)
☐Seasonal or Food Allergies (to ____________)
☐ Stomach problem (type ______________)
☐ Strep throat
☐ Thyroid problem
☐ Other ________________

Please list any surgeries your child has had and the approximate dates: ______________________________________

____

Has your child ever been hospitalized? ___No ___If yes, for what reason? ___________________________________
List medications your child takes and the dosages:

____

____

____

____

____

Are your child's immunizations up to date? __ No ___ Yes ___ Don't know
Please provide our office with a copy of your child's immunization records.

FAMILY MEDICAL HISTORY

	Father	Mother	Child	Sibling	Grandparent	Other
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma or Allergies	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer: type _______________	☐	☐	☐	☐	☐	☐
Depression, Anxiety	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Who lives at home with your child:
____

Does anyone at home smoke? ___No ___Yes

What grade is your child in? ____ If preschool-aged, who is the daytime caretaker?
____

Are there any problems at school? ___ No ___ If yes, specify:
____

Date: ___________ Parent Signature (or Legal Guardian) _________________________________