Charis Family Clinic PEDIATRIC Medical History Information (age 13 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)? _____

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

Please list any medications your child take and the dosages:_____

Does your child have a history of:

□ Anemia
□ Asthma
□ Attention Deficit/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 _____

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

Race (check all that apply): □ African-American □ Caucasian □ Native American □ Asian □ Hispanic/Latino □ Middle Eastern □ Polynesian □ Other _____
Ethnic/country background:_____
Preferred Language: _____ Other Languages spoken: _____
Who lives at home with your child: _____
Does anyone at home smoke? ___No ___Yes
What grade is your child in? ____ If preschool-aged or younger, who is the daytime caretaker? _____
Are there any problems at school? ___ No ___ If yes, specify: _____
Any animals in the home?_____

Date: _____ Parent Signature (or Legal Guardian) _____