

# Pediatric Patient History

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Completed by \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Who referred you to Mahoney Pediatrics: \_\_\_\_\_

**\*DATE OF LAST PHYSICAL EXAM:** \_\_\_\_\_

## Pregnancy & Birth:

Mother's Age at Pregnancy \_\_\_\_\_  
Hospital of Birth \_\_\_\_\_  
Birth Weight \_\_\_\_\_

During pregnancy did mother:  
(please circle all that apply)

Tobacco            Hepatitis B  
Alcohol            Group B Strep  
Drugs                Syphilis  
Hepatitis B        HIV  
Group B Strep

## Family Profile:

Parents: married single divorced  
List child's brother & sisters & their ages

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who resides in home?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Baby: (please circle all that apply)

Premature            C Section  
Jaundice             breathing problems  
Birth complications  
Breast feeding        formula

## Past Medical History:

Has /does your child:

y   n   have allergy to medicine

y   n   \_\_\_\_\_  
have other allergies

y   n   \_\_\_\_\_  
take medication

y   n   \_\_\_\_\_  
surgery (age & procedure)

y   n   \_\_\_\_\_  
been hospitalized (age & reason)

y   n   \_\_\_\_\_  
had serious injuries (age & description)

## Family Medical History:

Has anyone in your immediate family  
been treated for (please circle all that apply):

Anemia    Seizures    Cystic Fibrosis  
Asthma/Lung disease    Heart disease/murmur  
High blood pressure    High cholesterol  
Tuberculosis             Diabetes  
Thyroid Problems        Kidney disease  
other: \_\_\_\_\_

## Current Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any concerns about your child's development or behavior?

\_\_\_\_\_

