



**Pediatric Health History**

Patient's Name: \_\_\_\_\_ DOB \_\_\_\_\_ M F

Parent's Name: \_\_\_\_\_ Do other family members come to MRFM? \_\_\_\_\_

Why did you bring your child to the doctor today? \_\_\_\_\_

**Maternal & Newborn (if your child is under 2 years old)**

Length of your pregnancy \_\_\_\_\_

Baby's birth wt \_\_\_\_\_

Delivery method \_\_\_\_\_

Any problems at birth \_\_\_\_\_

Any problems during your pregnancy? \_\_\_\_\_

How many days in the hospital? \_\_\_\_\_

**What health problems has your child had? Please explain: Date began Medications (and dose):**

Congenital Y N \_\_\_\_\_

Nutrition Y N \_\_\_\_\_

Allergies Y N \_\_\_\_\_

Eyes, Ear/Nose/Throat Y N \_\_\_\_\_

Heart Y N \_\_\_\_\_

Lung Y N \_\_\_\_\_

Gastrointestinal Y N \_\_\_\_\_

Muscle/Bone/Joint Y N \_\_\_\_\_

Skin Y N \_\_\_\_\_

Blood Y N \_\_\_\_\_

Emotional/ADHD Y N \_\_\_\_\_

Other disease/conditions? Y N \_\_\_\_\_

Over-the-counter or herbal medications

**Allergies to medications (& reaction)**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

**Has your child seen any specialists? Date**

1 \_\_\_\_\_

2 \_\_\_\_\_

**Hospital Admissions/Surgeries Date**

1 \_\_\_\_\_

2 \_\_\_\_\_

**Your Child's Social History**

Does your child go to day care? \_\_\_\_\_

What grade in school is your child in? \_\_\_\_\_

School \_\_\_\_\_

Any problems in school? \_\_\_\_\_

Does your child have special interests (reading, sports, etc)? \_\_\_\_\_

\_\_\_\_\_

Any other pertinent circumstances? \_\_\_\_\_

**Family History Living? Health problems, or cause of death**

Father Age \_\_\_\_\_ Y N \_\_\_\_\_

Mother Age \_\_\_\_\_ Y N \_\_\_\_\_

Brother: Age \_\_\_\_\_ Y N \_\_\_\_\_

and Age \_\_\_\_\_ Y N \_\_\_\_\_

Sisters Age \_\_\_\_\_ Y N \_\_\_\_\_

Age \_\_\_\_\_ Y N \_\_\_\_\_

**Parents Social History**

Is Mom single/married/divorced? \_\_\_\_\_ When? \_\_\_\_\_

Mom's occupation? \_\_\_\_\_

Who lives in the home? \_\_\_\_\_

Other family nearby to help with child care? \_\_\_\_\_

Does anyone in the home use tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_

Does anyone in the home have serious health problems? \_\_\_\_\_

\_\_\_\_\_

How long have you lived in Tampa? \_\_\_\_\_

**PLEASE BRING YOUR CHILD'S  
IMMUNIZATION RECORD**

Signature \_\_\_\_\_ Date \_\_\_\_\_

