Pediatric Medical History Intake Form

Patient Information

Child's Full Name

Date of Birth

Sex

Select

Home Address

Parent/Guardian Name

Phone Number

Medical History

Primary Care Physician

Known Allergies (medications, food, etc.)

Current Medications

Previous Illnesses / Hospitalizations / Surgeries

Family Medical History

Are there any diseases that run in the child's family? (e.g., diabetes, asthma, heart disease, etc.)

Immunization History

Are the child's immunizations up to date?

Select

If no, which immunizations are missing?

Developmental History

Any complications during pregnancy or birth?

Did your child reach developmental milestones (sitting, walking, talking) on time?

Additional Information

Specific concerns or reasons for todayâ€™s visit

Other notes