Pediatric Medical History

Patient Information

Full Name: _____

Date of Birth: _____

Sex: _____

Parent/Guardian Name: _____

Contact Number: _____

Address:

Medical History

Primary Care Provider: _____

Current Medications:

Known Allergies:

Chronic Medical Conditions:

Past Hospitalizations/Surgeries:

Birth & Developmental History

Birth Weight: _____

Type of Delivery: _____

Any complications during pregnancy or birth?

Milestones (e.g., walking, talking):

Immunization History

Are immunizations up to date? __ Yes __ No

If not, which are pending?

Family History

Any family history of chronic illnesses?

Other relevant family medical history:

Social History

Who lives at home?

School/Daycare: _____

Any concerns about behavior or learning?

Other Notes

Date Completed: _____

Completed by: _____

Relationship to Patient: _____