Pediatric Medical History Questionnaire

Please complete all sections as accurately as possible. This form is for clinical records and will be printed.

1. Patient Information

Child's Full Name:

Date of Birth: MM/DD/YYYY

Gender:

Parent/Guardian Name:

Relationship to Child:

Phone Number:

2. Current Health Concerns

Reason for today's visit:

Current medications (include dosage):

Allergies to medications, food, or environment:

3. Birth and Development History

Birth Weight:

Were there any complications during pregnancy or birth?

Did the baby go home with the mother?

Are milestones (sitting, walking, speaking) being met on time?

4. Past Medical History

Has your child had any serious illnesses or chronic conditions?

Has your child ever been hospitalized or had surgery?

Are immunizations up to date?

5. Family History

Please list any significant family medical history (e.g., asthma, diabetes, heart disease):

6. Signature

Completed by (Print Name):

Signature:

Date: MM/DD/YYYY