



PEDIATRIC HISTORY FORM – CONFIDENTIAL

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
Age (yr & months) \_\_\_\_\_ Sex M / F Patient's Height \_\_\_\_\_ Patient's Weight \_\_\_\_\_  
Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Patient's Primary Physician \_\_\_\_\_ Send letters: Y / N  
Referring Physician (if different than above) \_\_\_\_\_

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What is the reason you are being seen in clinic today?  
\_\_\_\_\_  
If you are being seen due to injury please describe how and where injury happened? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Body Part(s) affected \_\_\_\_\_ Right \_\_\_\_ Left \_\_\_\_ Both \_\_\_\_  
Date of Onset: \_\_\_/\_\_\_/\_\_\_ Other MDs involved: \_\_\_\_\_

The problem is BETTER / WORSE / SAME since you first noticed it. (please circle one)  
**Please explain all YES answers.**  
There is a family history of the problem No Yes \_\_\_\_\_  
There is pain associated with the problem. No Yes \_\_\_\_\_  
There is a history of trauma / accidents involving the painful area. No Yes \_\_\_\_\_  
There is a history of broken bones or fractures. No Yes \_\_\_\_\_  
This problem has been previously treated. No Yes \_\_\_\_\_

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**Medical History**

Major Illnesses / Hospitalizations / Treatments	Treating Doctor / Facility
_____	_____
_____	_____
_____	_____
Surgery or Other Procedures	Treating Doctor / Facility
_____	_____
_____	_____
_____	_____

Current Medications (please list each medication and dosage)  
\_\_\_\_\_  
\_\_\_\_\_

Allergies (please include the medication and the reaction you experienced with each)  
\_\_\_\_\_  
\_\_\_\_\_

Please list all doctors patient is currently treated by and for what condition:  
\_\_\_\_\_  
\_\_\_\_\_

