77 **Pediatric Health Database**

Patient Name:_____

DOB:_____ Sex: M / F

Patient Phone #:_____

Medication Allergies/Reactions

Medication	Reaction	Medication	Reaction

Past Medical History

Problem	Onset	Problem	Onset
Anemia		Lung Disease	
Allergies		Obesity	
Asthma		Pneumonia	
Blood Transfusion		Premature Birth	
Diabetes		Problems in Pregnancy	
Ear Infections		Strep Throat	
Epilepsy		Urinary tract infection	
Febrile Seizure		Other	
Heartburn			
Hepatitis A B C			
HIV			
Irritable Bowel			

Past Surgical History

Procedure	Date	Procedure	Date
Adenoidectomy			
Circumcision			
Ear Tubes			
Hernia			
Tonsillectomy			
Other			

Birth History

born at __hospital __other_____

birth weight _____lbs_____oz_____in

mother's age_____

__nml delivery __C-Sec

__nml pregnancy __nml labor & delivery

__complications:

Hospitalizations

Date	Primary Problem

Injuries/Fractures

Date	Primary Problem

Family History

1°=primary family member (mother, father, brother, sister, child) 2°= any other family relative

If you do not know your family history, check here_____

Relation	Age	Living	Deceased (state cause of death)
Father			
Mother			
Brothers			
Sisters			

Check if your blood relative had any of the following diseases:

		Relationship to you
_____	allergies	
_____	arthritis, gout	
_____	asthma, hay fever	
_____	cancer, type?	
_____	___bone	
_____	___breast	
_____	___cervical	
_____	___colon	
_____	___lung	
_____	___liver	
_____	___pancreas	
_____	___skin	
_____	___other	
_____	chemical dependency	
_____	diabetes	
_____	heart disease	
_____	high blood pressure	
_____	kidney disease	
_____	rheumatic fever	
_____	seizures	
_____	stroke	
_____	thyroid	
_____	tuberculosis	

Social Information

Household	Siblings	Diet	Exercise	Care	Water Source
both parents	only child	bottle / breast	none	home	well
single parent	brother_____	eats_____x day	30 min / day	in home daycare	city
divorced parents	sister_____	_____oz day	1 hr / day	public daycare	
step parents		Multi vitamin	2 hr / day		

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