

**Vestavia Pediatrics
Patient Health History**

Patient Name: _____ **Date of Birth:** _____

Date of Last Well Check-up: _____ **Performed by:** _____

Siblings:

Name	Date of Birth

Does child have any allergies: () Yes () No. **If yes, list below**

Allergic to	Type of Reaction

Hospitalizations: () Yes () No. **If yes, note below:**

Date of Hospitalization	Hospital	Reason

Surgeries or Invasive Procedures: () Yes () No **If yes note below**

Date of Surgery	Type of Procedure	Reason for Procedure

Is child on any routine or chronic medications: () Yes () No **If yes list below**

Name of Medication	Strength	Dosage	Frequency

Does child have history of any of the following: Check circle all that apply

ADD/ADHD	Constipation	Fainting	Urinary/Kidney Problems
Allergic Rhinitis	Convulsions/Seizures	Hearing Problems	Vision Problems
Anemia	Developmental Delay	Heart Problems	List any other Problem below
Anxiety/Depression	Diabetes	Hepatitis	
Bleeding Problems	Drug/Alcohol Abuse	Mononucleosis	
Cancer	Ear Infections	Pneumonia	
Cerebral Palsy	Eczema	Speech Problems	
Chicken Pox	Epilepsy	Tobacco Use	

Is child up to date ofn the following immunizations? () Yes () No

DtaP___ Polio___ HiB___ Hepatitis B ___ Measles/Mump/Rubella___ Pevnar___ Ck Pox___

Date of Last Immunizations given; _____ -

Family History:

Has any member of the immediate family (parents, grandparents, sibling) been diagnosed with any of the following:

Circle all that apply:

ADD/ADHD	Development Delay	High Blood Pressure
Anxiely/Depression	Diabetes	Mental Disorders
Asthma	Drug/Alcohol Abuse	Migraine
Cancer	Heart Disease	Tobacco Use
Convulsions or Epilepsy	Hemophilia/Free Bleeder	

Social History :

Day Care: () Yes () No

With whom does the child reside; _____

Please, note any other health or social history that you feel your child's doctor should know in order to provide optimum care: _____

Signature: _____ **Date:** _____