Health History

Child's full name: _____ Date of birth: _____

Birth history

Born at (weeks): _____ Birth weight: _____

Any problems at birth?:

_____

Medical history

Health problems or diagnoses:_____

_____

Past surgeries or hospital stays: _____

_____

Current medicines (name and dose): _____

_____

Allergies (medicines, foods, other): _____

_____

Vaccines up to date? ☐ Yes ☐ No ☐ Not sure: _____

Family history

Asthma, diabetes, heart disease, mental health, or other conditions in the family:

_____

Social history

Who lives in the home?: _____

Smokers in the home? ☐ Yes ☐ No: _____

Pets: _____

School or daycare name: _____

Anything else you want the doctor to know?: _____

_____

_____

_____