RENAISSANCE PEDIATRICS, P.C.
Phone: (757) 488-2223 Fax: (757) 488-8398

Pediatric Health History Form

Date: _____

Patient's Name: _____ Birth date: ____/____/____

Mother's Name: _____ Age: _____ Health Problems: _____

Father's Name: _____ Age: _____ Health Problems: _____

Sibling(s) Name & Age: _____

Patient current medical problem(s): _____Date Began: _____

Current Medications: _____

Serious Illness, Injury, Hospitalizations:

Year	Type of Illness, Injury, Surgery
_____	_____
_____	_____

List any know drug allergies/reaction: _____

Birth Weight: _____ Length: _____ Gestation Age of Delivery: Early <38 wks Term 38-42 wks Late > 42 wks
Home with mom/dad? Yes No Why not: _____
Prenatal Complications: _____
Was your baby: Jaundiced - Yes / No Breast fed / Formula fed how long? _____
Delivery Hospital_____

Has your child ever had wheezing or bronchitis?	Yes	No	
Has your child ever had chicken pox?	Yes	No	Date/Age: _____
Do you have questions concerning the insertion of your car safety seat?	Yes	No	
Do you have the phone number to poison control?	Yes	No	
Do you wish to learn CPR?	Yes	No	
Do you have any questions to discuss with the provider?	Yes	No	

Please identify health problems in the patient or blood relatives:

Condition	***Patient/Relative***	***Condition***	***Patient/Relative***
Alcohol/Drug Addiction	_____	Genetic Disorders	_____
Allergies	_____	Heart Disease	_____
Anemia/Blood Disorders	_____	HIV/AIDS	_____
Asthma	_____	Kidney Disease/Bed Wetting Issues	_____
Behavior Problems	_____	Lung Disease	_____
Birth Defects	_____	Mental Illness/Retardation	_____
Bone/Joint Disease	_____	Muscle Disorders	_____
Cancer	_____	Rheumatic Fever	_____
Chronic Diseases	_____	Rheumatoid Arthritis	_____
Diabetes	_____	Seizures/Epilepsy	_____
Digestive Disorders	_____	Thyroid Disorders	_____
Eye/Ear Disorders	_____	Tuberculosis	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary healthcare services my child may need.

Signature of Parent: _____ Date: _____

Reviewed by provider: _____ Date: _____

Provider Comments: _____