Ridgefield Pediatric Associates, PC

Pediatric Health History Form

DATE: _____

Patient Name: _____ **DOB:**_____ **Sex: M** ___ **F** ____

Patient Medical History*:* **Birth Weight** _____ **Full Term** _____

Has your child ever had the following?

Allergies	Yes	No	Anemia	Yes	No
Birth Defects	Yes	No	Kidney/Bladder Disease	Yes	No
Chicken Pox	Yes	No	Genetic Defects	Yes	No
Whooping Cough	Yes	No	Measles	Yes	No
Heart Disease	Yes	No	Mumps	Yes	No
Asthma	Yes	No	Tonsillitis/Pharyngitis	Yes	No
Bronchitis	Yes	No	Ear Infections	Yes	No
Seizures/Convulsions	Yes	No	Epilepsy/Seizures	Yes	No
Blood Transfusions	Yes	No	Pneumonia	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No
Bone/Joint Problems	Yes	No	Psychological Issues	Yes	No
		No	Mental Illness	Yes	No

Hospitalizations/Surgeries/Serious Illnesses: _____

Current Medical Problems:

Please list current medical problems your child is experiencing now: _____

Current Medications:

_____

Any known drug allergies: _____Any other allergies: _____

Family History

Issue	Yes	No	Family Member	Issue	Yes	No	Family Member
Allergies	Y	N		Kidney Disease	Y	N	
Anemia	Y	N		Lung Disease	Y	N	
Asthma/Bronchitis	Y	N		Mental Illness	Y	N	
Birth defects	Y	N		Muscle Disorder	Y	N	
Bone/Joint Disorders	Y	N		Rheumatoid Arthritis	Y	N	
Cancer	Y	N		Seizures/Epilepsy	Y	N	
Diabetes	Y	N		Skin Disease	Y	N	
Eye/Ear Disorders	Y	N		Thyroid Disease	Y	N	
Genetic Defects	Y	N		Tuberculosis	Y	N	
Heart Disease	Y	N		Venereal Disease	Y	N	
High Blood Pressure	Y	N		High Cholesterol	Y	N	
HIV/AIDS	Y	N		Drug/Alcohol Abuse	Y	N	
				Depression	Y	N	