



Central Florida Pediatrics

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PATIENT HEALTH HISTORY

Date: _____ Child's Name: _____ D.O.B.: _____
Sex: M F Race: _____ Primary Language: _____

PATIENT HISTORY

Birthplace: _____ Hospital: _____ OB: _____

Delivery: Vaginal C-Section Full Term: Yes No # Weeks _____ Birth Weight: _____

Has the patient ever had (please check all that apply):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chickenpox _____ | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Allergic reaction |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Concussion/head injury | <input type="checkbox"/> Nervous Disorders | to any |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Neurologic Disorders | medications (list): |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Seizure Disorders | _____ |
| <input type="checkbox"/> Broken bone(s) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tonsilectomy | _____ |
| <input type="checkbox"/> Other _____ | | | |

Please list previous physicians familiar with child's medical history: _____

FAMILY HISTORY

	Name	DOB	Sex	If living— list all medical conditions	If deceased— list cause of death	Age at death
Father						
Mother						
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			

Has anyone in the immediate or extended family had (please check all that apply):

- | | | | |
|--|-------------|---|-------------|
| Illness | Who? | Illness | Who? |
| <input type="checkbox"/> AIDS | _____ | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Blood Disorders | _____ | <input type="checkbox"/> Mental disorders | _____ |
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Neurologic disorders | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Thyroid problems | _____ |
| <input type="checkbox"/> Heart Conditions | _____ | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Hepatitis, Type _____ | _____ | <input type="checkbox"/> Other _____ | _____ |

Does anyone in the household smoke? Yes No

Information provided by: _____ Relation to child: _____



Thank you for providing this information. If there are any items not listed on this form which you feel are pertinent to the care of your child, please feel free to review them during your visit.

PATIENT HEALTH HISTORY - PAGE 2

Child's Name:		DOB:	
Demographic Information			
Parent Last Name	First Name	DOB	Home Phone
Address			Cell Phone
City, State, Zip			Employer
Parent Last Name	First Name	DOB	Home Phone
Address			Cell Phone
City, State, Zip			Employer

Guardian / Step parent information (please circle one)		
Last name	First name	DOB
Last name	First name	DOB
Emergency Contact (Other than the parent of the child)		
Last name	First name	Phone number/Relationship
Last name	First name	Phone number/Relationship

PARENT PLEASE FILL OUT BELOW	
Hospitalizations(year and reason)/ Surgeries (year)	Allergies (foods or meds)/Reaction (ie rash, etc)
Specialists (if listed- reason why)	Medications (OTC or RX)/Dosage