PADILLA FAMILY MEDICAL CLINIC
PEDIATRIC HEALTH HISTORY

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

Present medical concerns: _____
_____
_____

Previous or ongoing medical problems: _____
_____
_____

Has this child had a serious illness, injury, hospitalization or operation?
_____**Yes** _____**No** **If yes, please explain** _____
_____
_____

Birth History: Birth weight:____ **Birth length:**____
Were there any problems during pregnancy, delivery or newborn period?
_____
_____

History of family illness: _____
_____
_____

Medications: (list if applicable with dosage and frequency) _____
_____
_____

Allergies: _____

Previous TB screening? ___**Yes** ___**No** ___**Unsure**

Are immunizations up to date? ___**Yes** ___**No** ___ **Unsure**

Name of person completing form: _____ **Date:** _____
Relationship to child: _____