PEDIATRIC HISTORY FORM

Patient's Name: ______________________________ □ Male □ Female

Date of Birth: ______________________ Age: ______________________

Maternal History

Mother's age when child was born __________ Hospital where child was born ______________

Number of pregnancies prior to this child ______________ Birth weight ______________

Medical problems during this pregnancy ______________________________

Was the delivery □ Vaginal □ Cesarean

Medical / Surgical History

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Medications

Including over the counter medications □ NONE

Name	Dose and Directions	Reason

Allergies

Please list all medication and food allergies if applicable □ NONE

Name	Reaction

Continued on reverse >

Stanford
HEALTH CARE

Household
Please list all those living in the child's home.

Name	Relationship to child

Immunization History
(You may also include a copy of the child's immunization record)

Name	Date Given