Columbus Medical Clinic
Pediatric Medical History Form

Patient Name: _____Date of Birth: _____Today's Date: _____

ALLERGIES

Allergies: ☐ No ☐ Yes, please list _____

CURRENT MEDICATIONS **(include over the counter medications, herbals, supplements, etc.)**

BIRTH HISTORY (For Newborns – Age 10)

Birth Weight: _____lbs_____ounces_____inches Place of Birth (Hospital Name: _____

Term Pregnancy? ☐ Yes ☐ No	Delivery: ☐ Vaginal (natural) ☐ C-Section
If no, how many weeks preterm? _____	Complications with delivery? ☐ Yes ☐ No If yes, please explain: _____

PERSONAL/FAMILY MEDICAL HISTORY

	Personal History	**Family History**	
Allergies	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Cancer, Types_____	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
CVA (Stroke)	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Diabetes Mellitus	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Tuberculosis (TB)	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	Family member: _____
Environmental Exposure	☐ Yes ☐ No		

HOSPITALIZATIONS

Reason for Hospitalization	**Date of Hospitalization**	**Hospital/Physician**

SURGICAL HISTORY

Type of Surgery	**Date of Surgery**	**Hospital/Physician**

SOCIAL HISTORY

	Alive?	Birth Year	Age at Death	Cause of death
Father	☐ Yes ☐ No			
Mother	☐ Yes ☐ No			

	How many?	# Alive	Birth Year(s)	If deceased, age and cause of Death
Brother(s)				
Sister(s)				

Parent's Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Members of Household: (please check all that apply)	☐ Parents ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ brother(s) ☐ sister(s) ☐ Grandparent ☐ Foster parents
Tobacco Smoke Exposure:	☐ Yes ☐ No If yes, who? _____
Daycare/School:	Grade Level: _____School: _____
Hobbies/Recreation: (please list)	

IMMUNIZATIONS

Date of Last Tetanus: _____ Date of Last Flu Vaccine: _____

OTHER MEDICAL PROVIDERS

Name:	Specialty:	Phone No.:
Name:	Specialty:	Phone No.:
Name:	Specialty:	Phone No.:

Signature: _____Printed Name: _____Date: _____