Union Mill Pediatrics
Patient History Form

Your child's name:_____ Date of Birth: _____

Birth History (If under 1 year old) Weight of child at birth? _____ Type of delivery? ☐vaginal ☐c-section
Complications? _____

Child's History Please list any medical condition your child is being treated for or has received therapy for in the past.

_____ _____

_____ _____

_____ _____

Medications currently taking _____

Allergies (medications, foods, insects, etc.)_____ Reaction _____

Hospitalizations/Surgeries _____

Special equipment of services required _____

Dentist? ☐ Yes ☐ No Ophthalmologist? ☐ Yes ☐ No

Specialist (if involved, please state reason)_____

Social History Please list all siblings with ages

_____ age: _____ _____ age: _____

_____ age: _____ _____ age: _____

Patient lives with _____
Parents are married/divorced?
Step parent? Y/N Foster parent Y/N

Pets?_____

Smokers? ☐ Yes ☐ No Inside/outside of house (circle both is applicable)

School or Daycare? ☐Yes ☐ No

House Built before 1968? ☐ Yes ☐ No

Recent foreign travel longer than three months? ☐ Yes ☐ No

Family History Do you or anybody in the immediate family have any of the following illnesses (please circle all that apply)?

Heart disease	Allergies	Seizures	Infant Seizures
Heart Attacks	Asthma	Low thyroid	Muscle or joint disease
High Cholesterol	Kidney problems	Juvenile diabetes	Arthritis or other rheumatoid conditions
Stroke	Hearing impairment	Alcohol or drug use	Depression or other psychiatric illness
High blood pressure	Tuberculosis	Cystic fibrosis	Other: _____

Cancer (please list all affected relatives): _____