Premier
MEDICAL GROUP

PEDIATRIC PATIENT HISTORY

Patient: _____ **Date of Birth**: _____

Family History: Please let us know about your family's health. Please answer these questions as completely as you can.

Please check the diseases that either Father or Mother have. For other relatives, circle F for Father's relatives and M for Mother's relatives.

Disease	Father	Mother	Grandmother	Grandfather	Patient's Brother/Sister(s)	Aunt	Uncle
ADD/ADHD			F M	F M		F M	F M
Allergies			F M	F M		F M	F M
Asthma			F M	F M		F M	F M
Birth Defects			F M	F M		F M	F M
Cancer			F M	F M		F M	F M
Coronary Artery Disease			F M	F M		F M	F M
DDH (Hip Dysplasia)			F M	F M		F M	F M
Deafness			F M	F M		F M	F M
Depression			F M	F M		F M	F M
Developmental Delay			F M	F M		F M	F M
Diabetes			F M	F M		F M	F M
Eczema			F M	F M		F M	F M
Genetic Disorder			F M	F M		F M	F M
Hemoglobinopathy (Sickle Cell)			F M	F M		F M	F M
High Cholesterol			F M	F M		F M	F M
High Blood Pressure			F M	F M		F M	F M
Learning Disability			F M	F M		F M	F M
Mental Retardation			F M	F M		F M	F M
Migraines			F M	F M		F M	F M
Obesity			F M	F M		F M	F M
Scoliosis			F M	F M		F M	F M
Seizure Disorder			F M	F M		F M	F M
SIDS (Sleeping Infant Death Syndrome)			F M	F M		F M	F M
Strabismus			F M	F M		F M	F M
Thyroid Disease			F M	F M		F M	F M
Other: _____			F M	F M		F M	F M

List any Chronic Illness your child has, if any:

_____

_____

_____

List any Surgeries your child has had with the dates of those surgeries:

Type of Surgery	Date of Surgery

List any Daily Medications your child takes:

Medication Name	Dose	How Many Times A Day

Is your child allergic to any medications: ☐ **Yes** ☐ **No** **If Yes, please list the medicine and reaction your child has:**

Medication Name	Allergic Reaction