SWEDISH
MEDICAL GROUP

Pediatric Health History (Birth to 18 yrs)

Last name: _____ First Name: _____

Date of Birth: _____ Sex: ☐Female ☐Male Preferred Name: _____

Parents' names: _____

Allergies (medications, other): _____

Current medications, vitamins/supplements (list dose & frequency): _____

_____

Please complete this section if patient is less than 12 months old

Birth History:

1. Prenatal history (please check the following applicable items):

	Maternal gestational diabetes		Positive maternal Hepatitis B
	Positive maternal HIV		Positive maternal Group B Strep (GBS)
	Newborn screening results: Normal		

2. Were there any prescription drugs taken during pregnancy? ☐Yes ☐No
3. Birth length: _____inches. Birth weight: _____lbs/oz.
4. Gestational age (weeks at birth):_____weeks.
5. Primary milk source (please check all that apply): ☐Formula fed ☐Breast fed ☐Solids
6. Any postnatal complications (problems in the newborn period):

Date	Medical Problem/Hospitalization/Surgery

Please complete the next two sections for all pediatric patients

Past Medical History (any significant medical problems, including hospital stays):

Date	Medical Problem/Hospitalization/Surgery

Family Medical History (Indicate family member. For extended family, note "Maternal" or" Paternal"):

Alcohol/Drug:		Ear problem:		Migraine:	
Allergies:		Eye problem:		Obesity:	
Alzheimer:		Genetic:		Psychiatry:	
Arthritis:		Gastrointestinal:		Respiratory:	
Asthma:		Bladder/kidney:		Schizophrenia:	
Bipolar:		Heart:		Sickle cell:	
Cancer:		Blood pressure:		Stroke:	
Depression:		Cholesterol:		Thyroid:	
Diabetes:		Mental illness:		Other:	

Status of patient's family:

Year	Mother	Father	Sibling	Sibling	Sibling	Sibling
Birth year or age						
Age at death						

If applicable, age at first menstrual period:_____