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PEDIATRIC HISTORY FORM

Child's Name: _____ Sex: ❑M ❑F Age: ___ DOB: _____

Parent's Name: _____

Drug Allergies (name of medicine and reaction): _____

Office Visit Authorization

I authorize _____ to chaperone _____ for medical visits to Dr. Susanna Chou's office.

Signed: _____ Date: _____

Relationship to patient: _____

Past Medical History

Prenatal (if answer yes, please explain)

Yes No

❑ ❑ 1. When you were pregnant with this child did you have any medical problems? _____
❑ ❑ 2. Did you have any complications with your labor? _____

Neonatal

1. Date of birth: _____ Due Date: _____
2. Baby's birth weight: _____
3. Any problems after baby were delivered? _____

Childhood Diseases

❑ ❑ 1. Has your child had any serious medical illness or hospitalizations? _____
❑ ❑ 2. Has your child had any operations? _____
❑ ❑ 3. Has your child had any injuries? _____
❑ ❑ 4. Has your child needed any medications? If yes, which ones, at what age? _____
❑ ❑ 5. Has your child had any delay in reaching developmental milestones? _____

Family History

Has either parent or any relative in either family had: (if yes, write relationship, age at time of disease, and if alive at present)

Y	N		Y	N	
❑	❑	Tuberculosis: _____	❑	❑	Diabetes: _____
❑	❑	Heart Diseases: _____	❑	❑	Asthma: _____
❑	❑	Cancer: _____	❑	❑	Mental Illness: _____
❑	❑	Alcoholism or Drug Abuse: _____	❑	❑	Other Diseases: _____

Social History

❑ ❑ 1. Is there any violent behavior in the family? _____
❑ ❑ 2. Does anyone in the family smoke? _____
3. List names and ages of all people who live with the child. _____
_____
_____

Parent's Signature: _____ **Date:** _____