Central Family Practice
720 W. 34TH Street, Suite 105
Austin, TX 78705

Pediatric Health History

Name _____ Date _____

Completed by _____ Relationship to child _____

Born at term ____ Yes ____ No If no, how many weeks gestation? _____

Complications during pregnancy or delivery? _____

Did mom smoke, drink, or use drugs during pregnancy? _____

Was baby born at home____ birthing center____ hospital____?

Did baby leave hospital same time as mom? _____ Yes _____ No

Jaundice or other problems after birth? _____

Past Illness _____

Problems today _____

Surgeries or hospitalizations _____

Major injuries _____

Medication _____

Herbs, vitamins or other supplements _____

Medication/Drug Allergies _____

_____

Date of immunization (if known):

Diphtheria, Tetanus, Pertussis (DTaP)	Polio	Hemophilus Influenza (Hib)	Hepatitis B	Measles, Mumps, Rubella (MMR)	Chicken Pox (Varicella)	Other Vaccines (list type and date)

Any relatives with:

___Asthma ___Cancer ___Anemia ___Tuberculosis ___Diabetes ___Heart Disease

___Seizures (convulsions) ___Mental impairment ___Kidney problems