Rocky Mountain Health Centers Pediatrics, P.C.

PEDIATRIC HISTORY (please print) DATE _____

PATIENT'S NAME _____
Last First Middle Nickname

BIRTHDATE _____ AGE _____ ☐ Male ☐ Female

FAMILY	Name	DOB	Occupation	Height
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Siblings	Name	DOB	full sibling	half-sibling	step-sibling
	_____	_____	☐	☐	☐
	_____	_____	☐	☐	☐
	_____	_____	☐	☐	☐
	_____	_____	☐	☐	☐
	_____	_____	☐	☐	☐

Others living in the home:	Name	Relation to patient
	_____	_____
	_____	_____

Pets (please list): _____

Smoking contacts (please list): _____

Marijuana use in the home? ☐ Yes ☐ No

Firearms in the home? ☐ Yes ☐ No Locked? ☐ Yes ☐ No

Parents are (select one): ☐ Married ☐ Divorced ☐ Other _____

Chronic medical problems, major illnesses, major injuries, and hospitalizations (please list):

Description	Month/Year or age of onset
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications taken daily: _____

Allergies to food or medicine? □ Yes □ No.
If yes, please list and describe type of reaction: _____

Immunizations up-to-date? □ Yes □ No
Any reactions to immunizations? □ Yes □ No. If yes, please describe: _____

BIRTH/DEVELOPMENTAL HISTORY

Type of delivery: □ Vaginal □ C section (reason for C section: _____)

Length of pregnancy: _____ Birth weight: _____ Birth length: _____

Any problems during pregnancy or in the newborn period? Please describe: _____
_____

Did your child meet his/her developmental milestones on time? □ Yes □ No
If no, please explain: _____

MEDICAL HISTORY (check all that apply):

Disease	N/A	Patient	Mother	Father	Sibling	Grandma (maternal)	Grandpa (maternal)	Grandma (paternal)	Grandpa (paternal)	*Please describe
Allergies										
Anemia/bleeding problems*										
Arthritis										
Asthma										
Birth defect										
Cancer*										
Eczema										
Eye disorder*										
Developmental Delay/Learning disorder*										
Diabetes										
Hearing loss*										
Heart attack										Age under 55? Y / N
High blood pressure										
Inherited disease* (e.g. muscular dystrophy, cystic fibrosis)										
Kidney or urinary tract disease										
Liver disease										
Lung disease										
Neurologic disease* (e.g. epilepsy)										
Psychiatric problems*										
Thyroid disease										
Stroke										
Death before age 50 other than accident*										Age under 55? Y / N

Other (please describe): _____

_____