

Pediatric Health History

Sterling Square Primary Care

Name _____ Birth Date ____/____/____ Gender M F
Last First M

Parent/Guardian _____ Parent/Guardian _____

Lives with _____

Any special spiritual or religious needs? yes no _____

Any special cultural needs? yes no _____

What language is spoken at home? _____

Any ALLERGIES to medications, x-ray dyes, foods, or other substances? yes no

Family Medical History (including heart disease before 55 years, TB, HIV, seizures, cancer, diabetes, etc.)

Mother	Birth Date	History
--------	------------	---------

Father		
--------	--	--

Grandparent		
-------------	--	--

Sibling/Other		
---------------	--	--

Birth History

Term Premature _____ weeks Late _____ weeks Birth weight _____

Vaginal delivery Cesarean section _____ Birth weight _____

Complications of pregnancy _____

Newborn complications Injuries Special Care

Breathing Problems Medications _____

Seizures _____

Jaundice _____

Was he/she discharged from the hospital at the same time as his/her mother? yes no