McKinney Pediatrics

Date: _____

# PEDIATRIC Health History

Your child's health is of the utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information is treated confidentially.

Child's Name: _____ Date of Birth: _____ Male ____ Female _____

Previous Physician: _____ Phone: _____ City/State: _____

Drug Allergies: _____ Medications:_____

**Please check and list any problem(s) your child has in any of the areas below:

| | | |
|---|---|---|
| | Eyes | |
| | Ears | |
| | Nose/Throat | |
| | Heart | |
| | Digestive System | |
| | Urinary System | |
| | Muscles/Joints/Bones | |
| | Skin | |
| | Behavior | |
| | Other | |

** Has your child had any hospitalizations or serious injuries? If so, please list_____

_____

| **FAMILY HISTORY** - Please circle any condition that any of the child's blood relatives have had and their relationship: | | | |
|---|---|---|---|
| *CONDITION* | *RELATIONSHIP* | *CONDITION* | *RELATIONSHIP* |
| | | | |
| Alcoholism | | HIV/AIDS | |
| Anemia | | Kidney Disease | |
| Asthma/Allergies | | Lung Disorder | |
| Autism | | Mental Disease/Disorder | |
| Birth Defects | | Muscular Disorder | |
| Bone/Joint Disorders | | Rheumatic Fever | |
| Cancer | | Seizure/Convulsions | |
| Diabetes | | Sickle Cell Disease | |
| Epilepsy | | Skin Disease | |
| Eye or Ear Disorder | | Stroke | |
| Genetic Defects | | Thyroid Disorder | |
| Heart Disease | | TB | |
| Hemophilia | | Cystic Fibrosis | |
| High Blood Pressure | | Other: | |

I acknowledge that the information contained herein is correct to the best of my knowledge.

Signature: _____ Relationship to patient: _____