A 2 Z Pediatrics
550 Boughton Rd. Ste. 110
Bolingbrook IL. 60440
(630) 755-5437(KIDS)

Pediatric Medical History:

Date: _____

Patient Name: (Last, First, Middle Initial)	Date of Birth:	Age:	Sex: ☐M ☐F
Father's Name: (Last, First)	Mother's Name: (Last, First)		
Form Completed by:	Relationship to Patient:		

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____
Is the child yours by ☐birth ☐adoption ☐stepchild ☐ other
Delivery by ☐vaginal ☐c-section
Complications: _____
Was your child premature ☐No ☐Yes, born at _____ weeks
Complications: _____
Birthweight _____ Length _____
Other problems in the newborn period: _____
_____
_____

Infancy/Childhood/Adolescence

Has your child ever been treated or diagnosed with: (Explain)
☐Asthma/Wheezing/Bronchitis _____
☐Seasonal Allergies or eczema _____
☐Food Allergy _____
☐Recurrent Ear Infection _____
☐Pneumonia _____
☐Urinary Tract Infection _____
☐Genetic Syndrome _____
☐Seizures _____
☐Anemia _____
☐Broken Bone _____
☐Mental Retardation/Learning Disability _____
☐Depression/Anxiety _____
Other chronic medical conditions: _____
_____
Has your child ever been hospitalized ☐No ☐Yes(explain)
_____
_____
Previous surgeries and dates
_____
Please list any specialists your child is currently seeing and reason:
_____
_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)
_____
_____
_____
Current medications and dose _____
_____
Vitamins _____
Herbal Supplements _____
Over-the-counter meds _____

Development/Nutrition

At what age did your child:
Walk alone:_____ Sit alone: _____
Toilet train:_____ Say words: _____
Was your child breastfed? ☐No ☐Yes, how long? _____
☐Both
Has your child had any unusual feeding/dietary problems?
_____
_____
Current milk intake: Type _____ Amount_____ oz/d

Family History

Do any family members have any of the following conditions?

Condition:	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐

Allergies: _____
_____
_____