BAY STREET PEDIATRIC ASSOCIATES, P.C.

Pediatric Health History Form

Date: _____

Patient Name: _____ D.O.B: _____ Sex: ___

Patient Medical History

Has your child ever had the following? (Circle Yes or No)

Allergies	Yes	No	Anemia	Yes	No
Birth Defects	Yes	No	Kidney/Bladder Issues	Yes	No
Chicken Pox	Yes	No	Measles	Yes	No
Whooping Cough	Yes	No	Mumps	Yes	No
Heart Disease	Yes	No	Tonsillitis	Yes	No
Asthma	Yes	No	Ear Infections	Yes	No
Bronchitis	Yes	No	Epilepsy/Seizures	Yes	No
Seizures/Convulsions	Yes	No	Pneumonia	Yes	No
Blood Transfusions	Yes	No	HIV/AIDS	Yes	No
Cancer	Yes	No	Psychological Issues	Yes	No
Bone/Joint Problems	Yes	No			

Hospitalizations/Surgeries/Serious Illnesses: _____

List current medical problems your child is experiencing now: _____

Current Medication: _____

Any known drug allergies: _____ Any other allergies: _____

Family History

Issue	Yes No	Family Member	Issue	Yes No	Family Member
Allergies			Kidney Disease		
Anemia			Lung Disease		
Asthma/Bronchitis			Mental Illness		
Bone/Joint Disorders			Mental Disorder		
Cancer			Seizures/Epilepsy		
Diabetes			Skin Disease		
Eye/Ear Disorders			Thyroid Disease		
Genetic Defects			Tuberculosis		
Heart Disease			High Cholesterol		
High Blood Pressure			Drug/Alcohol Abuse		
HIV/AIDS/STD			Other		