



Family Medical Care

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10625 N Military Trail, Suite 102
Palm Beach Gardens, FL 33410
PH: 561-249-7626 Fax: 561-429-7713

Pediatric Medical History

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Social Security Number : _____

Parent / Guardian: _____

Others in Household

Name	Age	Relationship

Please provide copy of immunization history

Allergies: Medications, Seasonal, other

Hospitalizations:

Reason	Date

Family History: Is there any family history of...

Anemia	Yes	No
Diabetes	Yes	No
Cancer (Type _____)	Yes	No
Heart Disease / Heart Attack	Yes	No
Lung Disease	Yes	No
Disease of Nervous system (seizures, etc.)	Yes	No
Allergies (asthma, hay fever, etc.)	Yes	No
Other inherited diseases _____	Yes	No

Social History:

Any daycare or school problems	Yes	No
Family Problems (siblings, divorce, death)	Yes	No
Anger / Discipline problems	Yes	No

Physical History: Has your Child had any of the following...

Asthma	Yes	No
Hay Fever	Yes	No
Ear infections	Yes	No
Eye problems	Yes	No
Frequent sore throats	Yes	No
Cough	Yes	No
Wheezing	Yes	No
Chest pain	Yes	No
Stomach pains	Yes	No
Poor appetite	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Urinary or menstrual problems	Yes	No
Complaints of pain	Yes	No
Growth or weight concerns	Yes	No
Speech problems	Yes	No
Hearing problems	Yes	No
Behavior problems	Yes	No
Frequent accidents/injuries	Yes	No

Parent / Guardian Signature _____ Date _____