# Partners in Health Healing Arts Center
# Pediatric Patient History Form

Name: _____ Date of Birth: _____

Birth History: (Full Term, Premature, Vaginal Delivery, C-Section, Required Oxygen, etc.)

Current Medical Problems: (I.E. Asthma, High Blood Pressure, Diabetes, Ulcers, etc)

Past Medical Problems: (Problems that have since been resolved)

Hospitalizations:

Surgeries:

Family History: (Cancer, Heart Disease, Diabetes, etc)

Are you on any prescription medicines, vitamins, or supplements? (list name, strength, dose)

Are you allergic to any medications?

Who does the child live with?

Are there smokers in the home? Yes ____ No ____

Are there any behavioral concerns with the child?

Why are you here today?