PATIENT HEALTH HISTORY

Hoag Medical Group Pediatrics

Patient Name: _____ Date: _____

Date of Birth: _____

Preferred Pharmacy: _____

Phone Number: _____ Address: _____

Allergies: Any known drug ☐ No ☐ Yes If yes, list: _____

Adverse reactions to vaccines? ☐ No ☐ Yes If yes, list vaccine and reaction: _____

Any environmental or food allergies? ☐ No ☐ Yes If yes, list: _____

Do you currently take any medications on a regular basis? ☐ No ☐ Yes

If yes, please list any medications that are taken on a regular basis (include non-prescriptions).

Medication	Dosage	Frequency

Medication	Dosage	Frequency

NOTE: If you are currently taking more medications that the space above allows, please list the additional medications on the back of this form.

PREGNANCY AND NEWBORN HISTORY

Any problems during pregnancy? ☐ No ☐ Yes If yes, specify: _____

Birth Hospital: _____ Birth Weight: _____

Delivery: ☐ Vaginal ☐ C-Section Delivery complications: _____

Term: ☐ Premature (___ weeks premature) ☐ Full Term

NICU: ☐ No ☐ Yes If yes, list medical problems: _____

Feeding: ☐ Breast Fed ☐ Formula Fed

hoag
Medical Group

Patient Name: _____ Date: _____
Date of Birth: _____

PATIENT MEDICAL HISTORY

List current medical problems: _____
List previous medical problems with dates: _____
List previous surgeries: _____
List any current pediatric specialists: _____
ER Visits and Hospitalizations: _____
Developmental Delays/Issues? ☐ No ☐ Yes _____

FAMILY HISTORY

(Include parents, siblings, grandparents, aunts and uncles only.)

- ☐ Alcoholism/Drug Abuse
- ☐ Asthma/Breathing Problems
- ☐ Bleeding/Clotting Disorders
- ☐ Cancer (Type: _____)
- ☐ Celiac Disease
- ☐ Crohns/Ulcerative Colitis
- ☐ Developmental Disorders
- ☐ Diabetes
- ☐ Genetic/Metabolic Disorders
- ☐ Hearing Impairment
- ☐ Heart Problems/Murmurs
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Mental Health Problems
- ☐ Migraines
- ☐ Neurological Disorders
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis

List any deaths of immediate family members: _____

SOCIAL HISTORY

List all people who live at home with patient:
Name: _____ Age: _____ Relationship to Patient: _____
Name: _____ Age: _____ Relationship to Patient: _____
Name: _____ Age: _____ Relationship to Patient: _____
Name: _____ Age: _____ Relationship to Patient: _____

ADDITIONAL INFORMATION

Is patient adopted? ☐ No ☐ Yes If yes, can this be discussed in front of patient? ☐ No ☐ Yes
County of Birth: _____ Foster Care? ☐ No ☐ Yes

Recognizing that medical history will affect diagnosis and treatment, I confirm that this Patient Health History is a full and complete statement of my child's pertinent medical history.

Parent/Guardian Signature: _____ Date/Time: _____

PATIENT LABEL