Inland Empire
CMG
Children's Medical Group

7101 Magnolia Avenue, Suite A • Riverside, CA 92504
Office (951) 682-9780 • Fax (951) 682-9787
www.iecmg.org

PEDIATRIC HEALTH HISTORY FORM

Child's Name:_____ Date of Birth:_____

Child's Previous Doctor: _____

BIRTH/NEWBORN HISTORY

❑ Male ❑ Female

Was baby born within 2 wks of expected day? ❑ Yes ❑ No ❑ Early ❑ Late

Delivery was: ❑ Vaginal ❑ Cesarean Birth Weight:

Birth/Delivery Complications: _____

Was baby jaundiced (yellow)? ❑ Yes ❑ No

How many days in hospital?_____ Breastfeeding? ❑ Yes ❑ No

ILLNESS AND INJURIES

Have you ever had:

Yes	No		Yes	No	
❑	❑	Mumps	❑	❑	Meningitis
❑	❑	Measles	❑	❑	Feeding problems
❑	❑	German measles	❑	❑	Hearing problems
❑	❑	Chickenpox	❑	❑	Vision problems
❑	❑	Seizures	❑	❑	Heart murmur
❑	❑	Asthma	❑	❑	Knocked unconscious
❑	❑	Breathing problems/snoring			
❑	❑	Broken bone(s)			
❑	❑	Urinary tract infection			
❑	❑	Pneumonia			
❑	❑	Seasonal allergies			

Any known drug or food allergies: _____

Hospitalizations/Surgeries: _____

Current Mediations: _____

_____

FAMILY HISTORY

Does mother(M), father(F), brother(B), sister(S), or grandparent(GP) have:

❑ Yes ❑ No Diabetes _____

❑ Yes ❑ No Epilepsy/seizures _____

❑ Yes ❑ No Mental retardation _____

❑ Yes ❑ No Heart Disease _____

❑ Yes ❑ No Cancer _____

❑ Yes ❑ No Kidney/Urinary Disease _____

❑ Yes ❑ No Bone/Joint problems _____

❑ Yes ❑ No High Blood Pressure _____

❑ Yes ❑ No Bleeding problems _____

❑ Yes ❑ No Asthma/Lung problems _____

❑ Yes ❑ No Eye or Ear Disorders _____

SOCIAL HISTORY

Number of people in home:_____ Are both parents in home ❑ Yes ❑ No

Is there ANY smoke exposure ❑ Yes ❑ No Language spoken at home:_____

Date Form Completed:_____

Signature:_____Relationship:_____

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