

Community Pediatric Medical Group, Inc.  
Child History Form

Please print clearly:

Child's name \_\_\_\_\_ Sex \_\_\_ DOB \_\_\_\_\_ Current age \_\_\_\_\_

Birth history: Birth weight \_\_\_\_\_

Circle one: Full term or premature, how many weeks \_\_\_\_\_

Vaginal or C-section, reason for C-section \_\_\_\_\_

Please describe any complications with pregnancy, delivery, after birth, or NICU stay:

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For older children, please also fill out below:

Any significant medical history you would like us to know:

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Please note any hospitalizations or surgeries below with dates:

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Please list any significant family history (such as diabetes, heart disease, high cholesterol, high blood pressure or cancer):

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Allergies to medications: \_\_\_\_\_

Allergies to foods: \_\_\_\_\_

Vaccines (please fill in dates or attach copy of immunization records):

Hep B \_\_\_\_\_

DtaP \_\_\_\_\_

Pneumococcal \_\_\_\_\_

Hib \_\_\_\_\_

IPV \_\_\_\_\_

Rotavirus \_\_\_\_\_

MMR \_\_\_\_\_

Varicella \_\_\_\_\_

HepA \_\_\_\_\_

Tdap \_\_\_\_\_

Meningococcal \_\_\_\_\_

Gardasil \_\_\_\_\_

Influenza \_\_\_\_\_

Mantoux \_\_\_\_\_

Other \_\_\_\_\_