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:

_____

_____

For older children, please also fill out below: Any significant medical history you would like us to know:

_____

_____

_____

Please note any hospitalizations or surgeries below with dates:

_____

_____

_____

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

_____

Allergies to medications:_____
Allergies to foods:_____

Office Use Only:

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

Hep B:_____
DtaP:_____
Pneumoccocal:_____
Hib:_____
IPV:_____
Rotavirus:_____
MMR:_____
Varicella:_____
HepA:_____
TdaP:_____
Meningococcal: _____
Gardasil:_____
Influenza:_____
Men B:_____
Mantoux: _____
Covid:_____
Other:_____