NextCare PRIMARY CARE

Pediatric Health Database

Name _____ Today's Date ___ / ___ / _____

Parent(s)/Guardian _____ Date of Birth ___ / ___ / _____

Birth History

Sex of child ___ Child is # ___ of ___ children

__ Vaginal delivery __ C-section (reason: _____)

__ Full term __ Pre-term

Complications _____

__ Breast fed __ bottle fed (formula: _____)

Medical/Surgical History

List any medical problems or surgeries child has had in the past

_____

_____

Social History

Smoker(s) in home? __ yes __ no

Pets in home? __ yes __ no

Gun in home? __ yes __ no

Pool at home? __ yes __ no

Family religious/spiritual preference? _____

Medications

List any medications child has taken in last year (include over-the-counter and herbal medicines)

_____

_____

Allergic or sensitivity reactions to any medication, product, or food

None __ List _____

Family History

Family Member	Health Problems	Cause of Death
Father		
Mother		
Brothers		
Sisters		
Children		
Grandparents		

Is there any history of sudden unexplained death in your family? _____

Names of other family members seen in our office _____