Today's Date: _____

Pediatric Medical History

This form is for children 12 years of age and under

Patient Name: _____ **DOB:** _____

Provider:_____

Pharmacy: _____

Allergies	Reactions

List all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers, and homeopathic remedies.

Medication Name Date Started	**Dose** (mg, units, drops)	**When Taken** (daily, at bedtime, etc.)	**Reason for Taking** (blood pressure, diabetes, etc.)

SURGICAL HISTORY **Date/Additional Information**

Tonsil/Adenoids ☐Yes ☐No **Date and/or year:** _____

Appendectomy ☐Yes ☐No **Date and/or year:** _____

Gallbladder Removal ☐Yes ☐No **Date and/or year:** _____

Hernia ☐Yes ☐No **Date and/or year:** _____

Fracture ☐Yes ☐No **Date and/or year:** _____**Location of Fracture**:_____

Other ☐Yes ☐No **Date and/or year:** _____