



Skagit Family Health Clinic
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PEDIATRIC MEDICAL HISTORY INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Today's Date: _____

HEALTH COMPLAINT/REASON FOR TODAY'S VISIT

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Birth History	
Date	Health Condition

MEDICAL HISTORY - List chronic, serious or significant health conditions with date of onset/diagnosis

Date	Health Condition

SURGICAL HISTORY - List surgeries and dates

Date	Surgery

MEDICATIONS/SUPPLEMENTS – List current prescription medications, over the counter medications and supplements

Name	Strength (e.g. 10 mg tablets)	How is it taken (e.g. 10 mg 2x a day)	Daily or as needed

Please complete other side. Thank you.

Additional Medical History

ALLERGIES - List all medication allergies and reactions	
Name of Medication	Brief description of your reaction (e.g. rash)

FAMILY MEDICAL HISTORY - List serious health conditions			
Relation	Health Conditions and/or Cause of Death	Age if Living	Age at Death
GRANPARENTS			
FATHER			
MOTHER			
BROTHERS			
SISTERS			

SOCIAL HISTORY	
Schooling: <i>Public Private Homeschooled</i>	Grade:
Exercise (<i>circle</i>): <i>Active 1/wkly 1-3/wkly 4+/wkly Sedentary Other:</i>	
<i>Diet:</i>	
<i>Foods that are avoided:</i>	
See dentist routinely?	

IMMUNIZATIONS HISTORY – List shots, date given and booster number if known (e.g. DTaP 1/2/11, #3)

ADDITIONAL MEDICAL INFORMATION – Please use the space below to list any other important information

If you need additional space to complete information use a separate piece of paper, attach to this form and check this box.
 Thank you.