Royal
KIDS
Pediatric Clinic

ROYALKIDS CLINIC
PATIENT HEALTH HISTORY FORM

Patient Name: _____ Date: _____

Date of Birth: _____

Preferred Pharmacy: _____

Phone Number: _____

Address: _____

Allergies:
Any known drug allergies? No Yes If yes, list: _____
Any environmental or food allergies? No Yes If yes, list:_____
Adverse reactions to vaccines? No Yes If yes, list vaccine and reaction:
_____

Do you currently take any medications on a regular basis?

No Yes. If yes, please list any medications that are taken on a regular basis (include non- prescriptions).

Medication	Dosage	Frequency
Medication	Dosage	Frequency

NOTE: If you are currently taking more medications that the space above allows, please list the additional medications on the back of this form.

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PREGNANCY AND NEWBORN HISTORY

Any problems during pregnancy? No Yes If yes, specify:
Birth Hospital: _____ Birth Weight _____
Delivery complications: _____ Delivery: Term: NICU:
Feeding:

Vaginal C-Section
Premature (___ weeks premature) No Yes If yes, list medical problems:
_____

Breast Fed Formula Fed

List current medical problems:
_____

List previous medical problems with dates:
_____

List previous surgeries:
_____

List any current pediatric specialists:
_____

ER Visits and Hospitalizations:
_____

Developmental Delays/Issues? No Yes

_____

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FAMILY HISTORY
(Include parents, siblings, grandparents, aunts and uncles only.)

__Alcoholism/Drug Abuse
__ Asthma/Breathing Problems
__Bleeding/Clotting Disorders
__Cancer (Type: _____)
__Celiac Disease Crohns/Ulcerative Colitis
__Developmental Disorders
__ Diabetes
__Genetic/Metabolic Disorders
__Hearing Impairment
__Heart Problems/Murmurs
__High Cholesterol
__High Blood Pressure
__Kidney Problems
__Mental Health Problems
__Migraines
__Neurological Disorders
__Seizures
__Stroke
__Thyroid Problems
__Tuberculosis
__List any deaths of immediate family members:
_____

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SOCIAL HISTORY

List all people who live at home with patient:

Name: _____
Age: _____ Relationship to Patient: _____

Name: _____
Age: _____ Relationship to Patient: _____

Name: _____

Age: _____ Relationship to Patient: _____

Name: _____

Age: _____ Relationship to Patient: _____

ADDITIONAL INFORMATION

Is patient adopted? No Yes

If yes, can this be discussed in front of patient? No Yes County of Birth:
_____

Foster Care? No Yes

Recognizing that medical history will affect diagnosis and treatment, I confirm that this Patient Health History is a full and complete statement of my child's pertinent medical history.
(Print Name):_____
Parent/Legal Representative
Signature: _____
Parent/Legal Representative
Date: _____Time:_____AM/PM