Pediatric Associates
of Kershaw County, PA

Patient History Form:

Patient name:_____ Date of Birth:_____

Child's Birth and Development History:

Born at:_____ Birth Weight:_____
(Name of Hospital)

Full term at Birth? Y or N If no, how many weeks at birth?_____

Type of Delivery (Vaginal or C-section): _____

NICU: Y or N If yes, Reason for NICU hospitalization:_____

Hepatitis B Vaccine date (if Newborn): _____

Any Chronic Illness: Please circle all that apply.

ADHD	Cystic Fibrosis	Cerebral Palsy	ODD
Asthma	Deafness	Sickle Cell Anemia	Bipolar
Blindness	Diabetes	Depression/Psychiatric	
Cancer	Epilepsy or Seizure	Other:_____	

Any Surgeries?_____

Current Medications:_____

_____

Allergies to Medications:_____

School:_____Grade in School:_____

Name of Person Completing Form:_____

Relationship to patient: _____

Signature:_____Date:_____