Promise Healthcare, dedicated to improving the health of the community through treatment, prevention, and education.

Pediatric Health History

Please complete form in its entirety.

Child's Name: ____ DOB: ____________________

Mother's name: ____ DOB: ____________________

Mother's occupation: ____

Father's name: ____ DOB: ____________________

Father's occupation: ____

Guardian's name: ____ DOB: ____________________

Guardian's occupation: ____

Who does the patient live with? Mother Father Both Parents Other (Specify): ______________________________

How many siblings live with the patient? ____

What is the child's primary language? ____

What other doctors has your child seen in the last year?

Please list: ____

____

Is your child allergic to any medications? YES NO

If yes, please list: ____

Does your child take any medicines (including vitamins and over-the-counter medicines)? YES NO

If yes, please list below:

Name of Medicine	Prescribed by (if not over-the counter)	Reason Taken	How long taken

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