Total Health Care Associates, PLLC
105 Ledford Mill Rd, Suite B
Tullahoma, TN 37388

Pediatric History Form

Welcome to our practice. Please answer the following questions below to the best of your ability.

Patient Name: _____ Date: _____

Birth Date: _____ Age _____ Gender: _____Male___or___Female_____

Name of previous physician/primary care provider: _____

Allergies/Reactions to any medications or vaccination: _____

Is your child taking any medications: □ YES □ NO If yes, please list below.

Medication	Dose	Medication	Dose

** Girls only: Age at first menstrual period _____

Immunizations

*Please bring your child's immunization record to appointments

Where did your child receive his/her immunizations_____

Are all immunizations up to date? □ YES □ NO

Pregnancy and Birth

Name/Address of hospital where child born _____

Please indicate any medical problems during pregnancy: □ NONE □ Specify: _____

Delivery by: □ Vaginal □ Caesarean – was it planned? □ YES □ NO Emergency – why? _____

Birth weight _____ Birth length _____ APGAR score 1 min _____ 5 min _____

Was your child premature: □ YES □ NO If so, how early? _____

Is/was your child breast fed? □ YES □ NO If breastfeeding, how long? _____

Is/was your child formula fed? □ YES □ NO If so, what type? _____

Family History

Medical condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Anemia								
Asthma								
Any cancer								
Heart attack /Heart disease								
Depression								
Diabetes								
Eczema								
High Cholesterol								
Hypertension								
Kidney disease								
Stroke								
Thyroid								