

Grove Pediatrics & Adolescent Medicine

3930 Pender Dr, Suite 330, Fairfax, VA 22030 | Tel: 703-246-0022 | Fax: 703-246-0080
www.grovekid.com | contact@grovekid.com

Medical & Family History Form

Patient Full Name:

Date of Birth:

Birth History (for patients under 2, or as applicable)

☐ Full-term ☐ Premature (____ weeks)

Birth Weight:

Delivery Type (Vaginal/C-Section):

Complications during pregnancy/delivery (if any):

Past Medical History

Hospitalizations (dates & reason):

Surgeries (dates & type):

Chronic conditions (asthma, diabetes, seizures, etc.):

Allergies

Medication allergies:

Food allergies:

Environmental allergies:

Current Medications

Medication	Dose	Frequency

Immunizations

☐ Up to date ☐ Not up to date ☐ Records attached

Developmental / Behavioral Concerns

☐ None ☐ Yes — please explain below

Explanation:

Family Health History

Please note any family history of: asthma, diabetes, heart disease, cancer, mental health conditions, or other significant conditions.

Relationship	Condition(s)
Mother	
Father	
Siblings	
Grandparents	

Grandparents

Social History

Household members:

☐ Pets in home ☐ Second-hand smoke exposure

Signature (Parent/Guardian):

Printed Name:

Daycare / School:

Date:

Relationship to Patient:
