Pediatric Health History Form

Name (optional) ________________

CHILD'S NAME: ______________________ **DATE OF BIRTH:** __________ **AGE:** __________

CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER: ______________________

PRESENT HEALTH CONCERNS: ______________________

____

MEDICINES/VITAMINS: ______________________

HERBS/HOME REMEDIES: ______________________

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: ______________________

PREGNANCY & BIRTH

Is this child yours by: ❑ birth ❑ adoption ❑ stepchild ❑ other ____________

Please indicate any medical problems during pregnancy ❑ none ❑ specify: ____________

____

Delivery by: ❑ vaginal birth ❑ caesarian If caesarian, why? ____________

Birth weight: __________ Birth length: __________ APGAR score 1 min. ______ 5 min. ______

Please indicate any medical problems during the baby's newborn period ❑ none If premature, how early? ______

other problems: ______________________

____

NUTRITION & FEEDING

Was your child breastfed? ❑ No ❑ Yes If so, how long? ____________

Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify: ____________

____

Milk intake now: Type ❑ cow milk (❑ non-fat ❑ 1%fat ❑ 2%fat ❑ whole milk) ❑ soy milk ❑ rice milk

Average ounces per day (Note: 8 ounces are in 1 cup) ____________

SLEEP

Hours per night ____________ Naps (number & length) ____________

Any sleep problems? ______________________

DEVELOPMENT

At what age did your child: sit alone ______ walk alone ______ say words ______ toilet train (daytime) ______

Girls only: Age at first menstrual period ____________

DENTAL HISTORY: Has child been seen by a dentist? ❑ No ❑ Yes If so, how often ______ Date of last visit ______

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.

Has your child had: ❑ chickenpox ❑ measles ❑ mumps ❑ rubella ❑ meningitis ❑ tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes

Do any household members smoke? ❑ No ❑ Yes

TV ---hours per day ______ Computer---hours per day ______ Video Games---hours per day ______

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates

____

____

____

Hospitalizations/Operations (with dates): ______________________

____

Broken bones or severe sprains ______________________

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-

FAMILY HISTORY: Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

SOCIAL HISTORY:

Birthplace____________________ Current (or upcoming) grade:____________________

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are the child's parents ❑ married ❑ unmarried ❑ separated ❑ divorced If divorced, when?__________

Parents' occupations: Mother ____________________ Father ____________________

Child care situation ❑ parents ❑ others (specify who and hours per day) ____________________

____

Concerns about your child: ❑ Alcohol use ❑ Tobacco ❑ Sexual Activity ❑ Aggressive Behavior

Is violence at home a concern? ❑ No ❑ Yes Are there guns in the home? ❑ No ❑ Yes

SCHOOL HISTORY:

Did/does your child attend preschool? ❑ No ❑ Yes Current grade________ Name of school__________

Any concerns about school performance? ____________________

Any concerns about relationships with: Teachers ❑ No ❑ Yes ____________________

Students ❑ No ❑ Yes ____________________

If over 4 years old does your child have a best friend? ❑ No ❑ Yes

Sports / exercise: Type_______________ How often?_______________ How long (minutes) ________

REVIEW OF ORGAN SYSTEMS: If child has more than one symptom on a line, circle the relevant one(s).

Constitutional / Endocrine
- ❑ Fevers/chills/excessive sweating
- ❑ Unexplained weight loss / gain

Eyes
- ❑ Squinting/"crossed" eyes/ asymmetric gaze

Ears / Nose / Throat
- ❑ Unusually loud voice/hard of hearing
- ❑ Mouth breathing/snoring
- ❑ Bad breath
- ❑ Frequent runny nose
- ❑ Problems with teeth/gums

Respiratory
- ❑ Cough/wheeze

Gastrointestinal
- ❑ Nausea/vomiting/diarrhea
- ❑ Constipation
- ❑ Blood in bowel movement

Cardiovascular
- ❑ Tires easily with exertion
- ❑ Shortness of breath
- ❑ Fainting

Genitourinary
- ❑ Bedwetting
- ❑ Pain with urination
- ❑ Discharge: penis or vagina

Neurological
- ❑ Headaches
- ❑ Weakness
- ❑ Clumsiness

Muscular / Skeletal
- ❑ Muscle/joint pain

Allergy
- ❑ Hayfever/itchy eyes

Skin
- ❑ Rashes
- ❑ Unusual moles

Psychiatric / Emotional
- ❑ Speech Problems
- ❑ Anxiety/stress
- ❑ Problems with sleep/ nightmares
- ❑ Depression
- ❑ Nail biting/thumbsucking
- ❑ Bad temper/breath holding/ jealousy

Blood / Lymph
- ❑ Unexplained lumps
- ❑ Easy bruising/bleeding

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-