Pediatric Health History Form

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

Where was your child born? _________________________________
Is the child yours by: Birth Adoption Stepchild Other: ________________________________
Please indicate any medical problems during pregnancy: None
Specify: ____
Delivery by: Vaginal birth Caesarean If Caesarean, 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 feeding/dietary problems? No Yes If yes, specify:
____
____
Milk intake now: Type: Cow's milk Nonfat 1% fat 2% fat Whole milk Soy milk Rice milk
Average ounces per day (Note: 8 ounces = 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_______
Water Source: City or Well? _________________________

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: ____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism____________________	High Cholesterol______________________
Cancer, specify type____________	High Blood Pressure___________________
Heart Attack___________________	Stroke______________________________
Depression/Suicide_____________	Other_______________________________
Diabetes______________________	Other_______________________________

SOCIAL HISTORY:
Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents: Married Unmarried Separated Divorced
If divorced or separated, when? _____________________________
Mother's Occupation ___________________________ Mother's Employer ______________________
Father's Occupation ___________________________ Father's Employer _______________________
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 school or preschool? No Yes
Current grade ___________ Name of school ____
Any concerns about school performance? ____
Any concerns about relationship with: Teachers No Yes Students No Yes
If more than 4 years old: does your child have a best friend? No Yes
Sports/exercise: Type _______________ how often? __________ how long (minutes)? ______

REVIEW OF SYMPTOMS: Please circle any current problems your child has on the list below:

Constitutional
Fevers/ chills/excessive sweating
Unexplained weigh loss/gain

Eyes
Squinting/ crossed eyes

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

Cardiovascular
Tires easily with exercise
Shortness of breath
Fainting

Respiratory
Cough/ Wheeze
Chest Pain

Gastrointestinal
Nausea/vomiting/ diarrhea
Constipation
Blood in bowel movement

Genitourinary
Bedwetting
Pain with urination
Discharge: penis or vagina

Musculoskeletal
Muscle/joint pain

Skin
Rashes
Unusual moles

Allergy
Hay Fever/ itchy eyes

Neurological
Headaches
Weakness
Clumsiness

Psychiatric/ Emotional
Speech problems
Anxiety/stress
Problems with sleep
Depression
Nail biting/thumb sucking
Bad temper/jealousy

Blood/ Lymph
Unexplained lumps
Easy bruising/ bleeding

Safety:
When your child is in the car does he use:
An infant seat
A booster seat
A seat belt only
Do you have smoke detectors at home? Yes or No
Dos your child wear a helmet for Bike/ Scooter or ATV? Yes or No