

Pediatric Health History Form

Your relationship to child: _____

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 unusual feeding/dietary problems? No Yes If yes, specify:

Milk intake now: Type Cow's milk (Nonfat
 1% fat 2% fat Whole)
 Soy milk Rice milk

Average ounces per day (Note: 8 ounces = 1 cup)

PATIENT LABEL

NAME: _____

DATE OF BIRTH: _____

AGE: _____

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 any of the following diseases:

- Chickenpox Measles Mumps
 Rubella Meningitis Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint) No Yes

Do any household members smoke? No Yes

TV – hours per day _____

Computers – hours per day _____

Video games – hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

Hospitalization/operations (with dates):

Broken bones or severe sprains:

FAMILY HISTORY

Please indicate any deaths 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 disease _____

Stroke _____

Depression/suicide _____

Bleeding or clotting disorder _____

Genetic disorders _____

Asthma/COPD _____

Diabetes _____

Other: _____

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level
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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 how often) _____

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

Peers 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 check any current problems your child has on the list below:

General

___ 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

Cardiovascular

___ Tires easily with exertion

___ 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

___ Sleep issues

___ Depression

___ Nail biting/thumb sucking

___ Bad temper/breath holding/jealousy

Blood/Lymph

___ Unexplained lumps

___ Easy bruising/bleeding