

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 unusual 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 _____

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 with a check (✓) family members who have had any of the following conditions:

Medical Condition	Admin use only	Mom 1	Dad 2	Sister 3	Brother 4	Mom's Mom 5	Mom's Dad 6	Dad's Mom 7	Dad's Dad 8	Mom's Sister 12	Mom's Brother 13	Dad's Sister 14	Dad's Brother 15
Alcoholism	33												
Anemia	1												
Asthma	5												
Autoimmune Disorder	34												
Bleeding Problem	7												
Cancer, Breast	8												
Cancer, Melanoma	10												
Cancer, Ovary	11												
Congenital Anomaly/Birth Defect	36												
Heart Attack/Heart Disease	13												
Depression	14												
Diabetes, on insulin shots	37												
Diabetes, not on insulin	38												
Eczema	17												
Food Allergy	39												
Genetic Disorder	19												
Hay Fever	20												
Hearing Disorder	21												
High Cholesterol	22												
High Blood Pressure	23												
Immune Disorder	24												
Kidney Disease	25												
Mental Retardation or Learning Disability	40												
Stroke	28												
Substance Abuse	43												
Thyroid Disorders	30												
Tobacco Use	30.5												
Tuberculosis	31												
Death before age 56 for reason not listed above													
Other:													
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 check (✓) any current problems your child has on the list below:

Constitutional

___ Fever/chills/excessive sweating

___ Unexplained weight loss/gain

Eyes

___ Squinting/"crossed" eyes/
asymmetric gaze

Ear/Nose/Throat

___ Unusually loud voice/hard of
hearing

___ Mouth breathing/snoring

___ Bad breath

___ Frequently 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

___ Problems with sleep/nightmares

___ Depression

___ Nail biting/thumb sucking

___ Bad temper/breath holding/
jealousy

Blood/Lymph

___ Unexplained lumps

___ Easy bruising/bleeding

Please indicate any other concerns you want to discuss today: