Pediatric Health History Form

Child's Name:

_____

Child's previous doctor/primaryCare 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 _____

At how many weeks was your child born_____

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:

Formula- avg ounces per day_____

Cow's milk (Nonfat _____, 1% fat _____, 2% _____, Whole _____)

Average ounces per day _____

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 _____

Rubella _____ Meningitis _____

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 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 _____

Other: _____

SOCIAL HISTORY

Who lives at home?

Name Age Relationship Highest Education level

_____

_____

_____

_____

Is violence at home a concern? No Yes

Are there guns in the home? No Yes

If yes, are they locked away from child? No Yes

Are your child's parents: Married Unmarried

Separated Divorced

If divorced or separated, when? _____

How much time is spent with:

Mother:_____

Father:_____

Other:_____

Mother's Occupation:_____

Mother's Employer:_____

Father's Occupation:_____

Father's Employer:_____

Child care situation: Parents Daycare Other

(Specify who and how often)_____

_____

Concerns about your child:

Alcohol use, Sexual activity, Aggressive behavior

Tobacco

Other:_____

SCHOOL HISTORY

Did/does your child attend school or preschool?

No Yes

Current grade _____

Name of school _____

Any concerns about school performance? No Yes

Please List:_____

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)? _____

Anything else you would like to tell us about your child? (likes/dislikes, fears, favorite things)

_____

_____

_____

_____

_____

REVIEW OF SYMPTOMS: **Details:**

Please circle any current problems your child currently has on the list below:

Eyes: Squinting, crossed eyes, asymmetric gaze

Ears/Nose/Throat: Unusually loud voice, difficulty hearing, mouth breathing/snoring, chronic bad breath, frequent runny nose, problems with teeth/gums

Cardiovascular: Tires easily with exertion, shortness of breath, fainting

Respiratory: cough, wheezing, chest pain

Gastrointestinal: nausea, vomiting, diarrhea, constipation, blood in stool, reflux, frequent abdominal pain

General: fevers, chills, excessive sweating, unexplained weight loss/gain

Genitourinary: **be**dwetting, pain with urination, frequent accidents

Musculoskeletal: muscle pain, joint pain

Skin: rashes, unusual moles, severe sunburns #____

Allergy: hay fever, itchy eyes, food allergies

Please list: _____

Neurological: headaches, weakness, clumsiness

Psychiatric/Emotional: Speech problems, anxiety/stress, sleep issues, depression , nail biting, thumb sucking, bad temper, breath holding, jealousy issues, concerns for bullying

Blood/Lymph: unexplained lumps, easy bruising