

## PEDIATRIC HEALTH HISTORY

**Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated confidentially.**

Child's Name: \_\_\_\_\_

M  F

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

### IDENTIFICATION

Name of Person completing form: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

### SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parents are:  Married  Single  Divorced  Separated  Other: \_\_\_\_\_

Childcare/School Information:

Does anyone smoke around the patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any guns in the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any pets in the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### BIRTH HISTORY

Is this child yours by:  Birth  Adoption  Stepchild  Other: \_\_\_\_\_

Birth Hospital: \_\_\_\_\_ Gestational Age: \_\_\_\_\_ wks Birth Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Problems during Pregnancy

Type of delivery (circle): C/S    Vaginal  
If C/S why? \_\_\_\_\_

Feeding Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Breathing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other problems	_____				

### FEEDING HISTORY

Breast Fed  How long? \_\_\_\_\_ Bottle Fed  Formula Name \_\_\_\_\_

Current Diet: Baby Food  Table Food  Appetite (Circle one)    Good    Fair    Poor

Vitamins/Supplements  Yes  No    If yes, please list \_\_\_\_\_

### DEVELOPMENTAL HISTORY

At what age did your child: Roll Over \_\_\_\_\_ Sit Alone \_\_\_\_\_ Walk Alone \_\_\_\_\_

Say Words \_\_\_\_\_ Toilet Trained \_\_\_\_\_ Known Developmental delay or problems?  Yes  No  
If yes, please list \_\_\_\_\_

**PAST MEDICAL HISTORY**

Current Medications: Please List

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: Please List

Medications: \_\_\_\_\_

Food: \_\_\_\_\_

Environmental: \_\_\_\_\_

Previous Surgeries or Hospitalizations: (Please list procedure or reason for hospitalization and dates)

Procedure/Reason	Dates
_____	_____
_____	_____
_____	_____

Please check  if child has ever had any of the following:

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	Eye/Vision Problems	<input type="checkbox"/>	Ear/Hearing Problems
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Heart Condition
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Recurrent Ear Infections	<input type="checkbox"/>	Recurrent Nose Bleeds	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	Stomach/Bowel Problems	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Weight Loss/Gain
<input type="checkbox"/>	Urine/Kidney Infections	<input type="checkbox"/>	Bedwetting/Soiling	<input type="checkbox"/>	Skin Rashes/Eczema	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Bone Problems/Fractures	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Joint Pain/Swelling	<input type="checkbox"/>	Convulsions/Seizures
<input type="checkbox"/>	ADHD/Learning Issues	<input type="checkbox"/>	Discipline Issues	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Mood Swings
<input type="checkbox"/>	Nervousness/Unusual Fears	<input type="checkbox"/>	Social Issues	<input type="checkbox"/>	Sleep Problems	<input type="checkbox"/>	
<input type="checkbox"/>	History of Tobacco/Drug/Alcohol use	<input type="checkbox"/>	History of Sexual Abuse	<input type="checkbox"/>	History of Physical Abuse	<input type="checkbox"/>	

If female, started her period Age of onset \_\_\_\_\_ Problems: \_\_\_\_\_

Other Medical Problems: \_\_\_\_\_

**FAMILY HISTORY**

Please check  any conditions that apply and relationship to patient

<input type="checkbox"/>	Alcoholism/Substance Abuse	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Mental Disease/Disorder
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Seizures/Convulsions
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	HIV/Immune Deficiency	<input type="checkbox"/>	Seasonal Allergies

Other Medical Problems: \_\_\_\_\_