

Pediatric Health History Form

Name (optional)

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

Is the child yours by: birth adoption stepchild other: _____

Please indicate any medical problems during pregnancy none specify: _____

Delivery by vaginal birth caesarian If caesarian, 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 milk (non-fat 1% fat 2% fat whole milk) soy milk rice milk
Average ounces per day (Note: 8 ounces are in 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 circle any family history of the following (indicate who has/had the condition):

- | | | |
|------------------------|---------------------------------------|----------------|
| Alcoholism/drug abuse | Heart disease or stroke before age 60 | Seizures |
| Psychiatric disorders | Thyroid disease | Kidney disease |
| High blood pressure | Bleeding/clotting problems | Birth defects |
| Asthma/hayfever/eczema | Inherited/genetic diseases | |

SOCIAL HISTORY:

Birthplace _____ Current (or upcoming) grade: _____

Who lives at home?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Highest Education level</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the child's parents married unmarried separated divorced If divorced, when? _____

Parents' occupations: Mother _____ Father _____

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 preschool? No Yes Current grade _____ Name of school _____

Any concerns about school performance? _____

Any concerns about relationships with: Teachers No Yes _____

Students No Yes _____

If over 4 years old does your child have a best friend? No Yes

Sports /exercise: Type _____ How often? _____ How long (minutes) _____

REVIEW OF ORGAN SYSTEMS: If child has more than one symptom on a line, circle the relevant one(s).

Constitutional / Endocrine

- 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

Respiratory

- Cough/wheeze

Gastrointestinal

- Nausea/vomiting/diarrhea
- Constipation
- Blood in bowel movement

Cardiovascular

- Tires easily with exertion
- Shortness of breath
- Fainting

Genitourinary

- Bedwetting
- Pain with urination
- Discharge: penis or vagina

Neurological

- Headaches
- Weakness
- Clumsiness

Musculo / Skeletal

- Muscle/joint pain

Allergy

- Hayfever/itchy eyes

Skin

- Rashes
- Unusual moles

Psychiatric / Emotional

- Speech problems
- Anxiety/stress
- Problems with sleep/nightmares
- Depression
- Nail biting/thumbsucking
- Bad temper/breath holding/jealousy

Blood / Lymph

- Unexplained lumps
- Easy bruising/bleeding

—PLEASE COMPLETE BOTH SIDES OF THIS FORM—