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 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_____
Water Source: City or Well?_____

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 the current status 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 Attack	_____	Stroke	_____
Depression/Suicide	_____	Other	_____
Diabetes	_____	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

- Fevers/ chills/excessive sweating
- Unexplained weigh loss/gain

Eyes

- Squinting/ crossed eyes

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 exercise
- 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

Safety:

When your child is in the car does he use:

An infant seat
A booster seat
A seat belt only

Do you have smoke detectors at home Yes or No

Dos your child wear a helmet for Bike/ Scooter or ATV Yes or No