

| **HEALTH HISTORY FORM - Pediatric** |
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**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Chart#:**\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Child’s Age:**\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD’S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRESENT HEALTH CONCERN**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICINES / VITAMINS Currently Taking** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES / REACTIONS** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREGNANCY & BIRTH**

Is this child yours by 𐄂birth 𐄂adoption 𐄂stepchild 𐄂other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any medical problems during pregnancy: 𐄂none 𐄂specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery by 𐄂vaginal birth 𐄂C/section-If C/section, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth length\_\_\_\_\_\_\_\_\_\_\_\_ APGAR score 1 min\_\_\_\_\_\_\_ 5min\_\_\_\_\_\_

Please indicate any medical problems during the baby’s newborn period 𐄂none 𐄂specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If premature how early? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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)

Has your child missed any vaccinations? 𐄂No 𐄂Yes Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Hospitalizations / Operations (with dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 / hay fever / eczema Inherited/genetic diseases

**SOCIAL HISTORY** Birthplace/City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in the house with your child?

𐄂Mother 𐄂Father 𐄂Brother/s (number \_\_\_\_\_) 𐄂Sister/s (number\_\_\_\_\_)

𐄂Stepmother 𐄂Stepfather 𐄂Grandmother 𐄂Grandfather

𐄂Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

𐄂Home Schooled 𐄂Daycare (days/week\_\_\_\_\_) 𐄂Home Daycare (# of other kids \_\_\_\_\_ days/week\_\_\_\_\_)

𐄂School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current (or upcoming) grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

𐄂Sports / exercise? Type, How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

𐄂Any concerns about school performance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Concerns about your child? 𐄂Alcohol use 𐄂Tobacco 𐄂Sexual Activity 𐄂Aggressive Behavior

Is violence at home a concern? 𐄂No 𐄂Yes

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

Constitutional / Endocrine Gastrointestinal Allergy

𐄂Fevers/chills/excessive sweating 𐄂Nausea / vomiting / diarrhea 𐄂Hayfever / itchy eyes

𐄂Unexplained weight loss / gain 𐄂Constipation Skin

Eyes 𐄂Blood In bowel movement 𐄂Rashes

𐄂Squinting / crossed eyes/ Cardiovascular 𐄂Unusual moles

𐄂asymmetric gaze 𐄂Tires easily with exertion Psychiatric / Emotional

Ears / Nose / Throat 𐄂Shortness of breath 𐄂Speech Problems

𐄂Unusually loud voice / hard of 𐄂Fainting 𐄂Anxiety/stress

hearing Genitourinary 𐄂Problems with sleep /

𐄂Mouth breathing/snoring 𐄂Bedwetting 𐄂nightmares

𐄂Bad breath 𐄂Pain with urination 𐄂Depression

𐄂Frequent runny nose 𐄂Discharge penis or vagina 𐄂Nail biting / thumbsucking

𐄂Problems with teeth / gums Neurological 𐄂Bad temper/breath holding/

Respiratory 𐄂Headaches jealousy

𐄂Cough / wheeze 𐄂Weakness Blood / Lymph

Muscular/Skeletal 𐄂Clumsiness 𐄂Unexplained lumps

𐄂Muscle/joint pain 𐄂Easy bruising/bleeding

**CHECK YOUR PATIENT PORTAL TO REQUEST FUTURE PRESCRIPTION**

**REFILLS, CHECK LAB RESULTS & MORE!**

| **SIGNATURE** *(Parent/Legal Guardian)* |  |
| --- | --- |
| **\*\*PRINT NAME:** |  |

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