



## 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: \_\_\_\_\_ Today's 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?  Yes  No

Are there any guns in the home?  Yes  No

Are there any pets in the home?  Yes  No

### Birth History

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

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

Problems during pregnancy \_\_\_\_\_

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

Feeding Problems  Yes  No Jaundice  Yes  No

Breathing Problems  Yes  No Seizures  Yes  No 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 you 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:

- Asthma
- Allergies
- Bronchitis
- Pneumonia
- Whooping Cough
- Chicken Pox
- Measles
- Mumps
- Dental problems
- Speech Problems
- Eye/Vision Problems
- Ear/Hearing Problems
- Fainting
- Dizziness
- Chest Pain
- Heart Condition
- Headaches
- Recurrent Ear Infections
- Recurrent Nosebleeds
- Anemia
- Bleeding Problems
- Stomach/Bowel Problems
- Constipation
- Weight Loss/Gain
- Urine/Kidney Infections
- Bedwetting/Soiling
- Skin Rashes/Eczema
- Sickle Cell Disease
- Bone problems/Fractures
- Scoliosis
- Joint Pain/Swelling
- Convulsions/ Seizures
- ADHD/Learning Issues
- Discipline Issues
- Depression
- Mood Swings
- Nervousness/Unusual Fears
- Social Issues
- Sleep Problems
- History of Tobacco/Drug/Alcohol use
- History of Sexual Abuse
- History of Physical Abuse
- If female, started her period Age onset \_\_\_\_\_ problems ? \_\_\_\_\_
- Other Medical Problems: \_\_\_\_\_

**Family History**

Please check  any conditions that apply and relationship to patient

- Alcoholism/Substance Abuse \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Asthma \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Mental disease/disorder \_\_\_\_\_
- Cancer \_\_\_\_\_
- Seizures/convulsions \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Stroke \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- HIV/Immune Deficiency \_\_\_\_\_
- Seasonal Allergies \_\_\_\_\_
- Other: (Please list) \_\_\_\_\_