ESD Pediatric Group
Englender, Sper & Drasnin, MD's, Inc.

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 pets in the home? Yes☐ No☐

Are there any guns in the home? Yes☐ No☐ Does your child use sunscreen? 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: Vaginal☐ C-Section☐ If C-Section, what was the reason: _____

Feeding Problems Yes☐ No☐ Jaundice Yes☐ No☐

Breathing Problems Yes☐ No☐ Seizures Yes☐ No☐ Other Problems?_____

Feeding History

Breast Fed Yes☐ No☐ How Long?_____ Bottle Fed Yes☐ No☐ Formula Name: _____

Current Diet: Baby Food☐ Table Food☐ Appetite 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

Please list Current Medications:

_____ _____ _____
_____ _____ _____

Please list Allergies:
Medications: _____ Food: _____ Environmental: _____
_____ _____ _____

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

Procedures/Reason	Dates
_____	_____
_____	_____
_____	_____

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

☐ Asthma	☐ Allergies	☐ Scoliosis	☐ Recurrent Nosebleeds
☐ Whooping Cough	☐ Chicken pox	☐ Discipline Issues	☐ Constipation
☐ Dental problems	☐ Speech Problems	☐ Social Issues	☐ Skin Rashes/Eczema
☐ Fainting	☐ Dizziness	☐ Mood Swings	☐ Joint Pain/Swelling
☐ Headaches	☐ Headaches	☐ Bronchitis	☐ Depression
☐ Bleeding Problems	☐ Recurrent Ear Infections	☐ Measles	☐ Sleep Problems
☐ Urine/Kidney Problems	☐ Stomach/Bowel Problems	☐ Eye/Vision Problems	☐ Pneumonia
☐ ADHD/Learning Issues	☐ Bedwetting/Soiling	☐ Chest Pain	☐ Mumps
☐ Nervousness/Unusual Fears	☐ Heart Conditions	☐ Anemia	☐ Ear/Hearing Problems
☐ Weight Loss/Gain	☐ Sickle Cell Disease	☐ Convulsions/Seizures	☐ Bone Problems/Fractures

History of Tobacco/Drug/Alcohol use? Yes ☐ No ☐ History of Sexual Abuse? Yes ☐ No ☐
History of Physical Abuse? Yes ☐ No ☐

If female, started her menstrual cycle? Yes ☐ No ☐ If yes, onset age _____ Any problems: Yes ☐ No ☐
Other Medical Problems: _____

Family History

Please check ☐ any conditions that any of the child's blood relatives (including parents and siblings) have had and the relationship to the child:

☐ 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)	_____		
	_____		