Name Date

**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**

Is this 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 mm 5min

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

# SLEEP

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)

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/pluming/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?

Name Age Relationship Highest Education Level

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 | Gastrointestinal Nausea / vomiting / diarrhea | Allergy 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 |
|  Clumsiness |  |  Unexplained lumps |
| Muscular/Skeletal |  |  Easy bruising/bleeding |

 Muscle/joint pain