



Pediatric Health History Form

Child's Name: _____ Date of birth: _____ Age: _____

Child's Primary Care Provider: _____

Present Health Concerns: _____

Medicines/Vitamins: _____

Herbs/Home Remedies: _____

Allergies/Reactions to Medicines or Vaccinations: _____

Pregnancy and Birth

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: _____

Please indicate any medical problems during the baby's newborn period: None Specify _____

Other problems: _____

Nutrition and Feeding

Was your child breastfed? Yes No If yes, how long? _____

Has your child had any unusual feeding/dietary problems? Yes No

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 (8oz = 1cup) _____

Sleep

Hours per night _____ Naps (number & length) _____

Any sleep problems? _____

Development

Age your child: Sat alone _____ Walked alone _____ Said words _____ Toilet train (daytime) _____

Girls only: Age at first menstrual period _____

Dental History

Has your child been seen by a Dentist? Yes No If yes, how often? _____ Date of last visit _____

Immunizations/Infectious Diseases

Has your child had: Chicken Pox Measles Mumps Rubella Meningitis Tuberculosis (TB)

Exposures/Habits: Any concerns about lead exposure? (old home/plumbing/paint) Yes No

Do any members of your household smoke? Yes No

TV hours per day _____ Computer hours per day _____ Video game-hours per day _____

Past Medical History _____

Hospitalizations/operations (with dates): _____

Broken or severe sprains: _____

Family History: Has any family member had any of the following:

<i>Medical Condition</i>	<i>Who</i>
Cancer	_____
Heart Disease	_____
Diabetes	_____
Other _____	_____

Social History: Who lives at home?

Name	Age	Relationship	Highest Level of education
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are your child's parents Married Unmarried Separated Divorced If divorced/separated, when _____

Mother's Occupation _____ Mother's Employer _____

Father's Occupation _____ Father's Employer _____

Child care situation Parents Others (specify who & hours per day) _____

Concerns about your child: Drugs/Alcohol use Tobacco Sexual Activity Aggressive behavior

Is violence a concern at home? Yes No Are there guns in the home? Yes No

School History

Any concerns about school performance? _____

Any concerns about relationship with: Teachers Yes No Students Yes No

Sports/exercise: Type _____ How often _____ How long (minutes?) _____

Review of Symptoms: Please check any current problems your child has on the list below:

Constitutional

- Fever/chills/excessive sweating
- Unexplained weight loss/gain

Eyes

- Squinting/"crossed" eyes/
asymmetric gaze

Ear/Nose/Throat

- Unusually loud voice/hard of hearing
- Mouth breathing/snoring
- Bad breath
- Frequently runny nose
- Problems with teeth/gums

Cardiovascular

- Tires easily with exertion
- Shortness of breath
- Fainting

Trauma

- Struck unconscious
- Near death experience

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
- Easy bruising/bleeding

Allergy

- Hay fever/itchy eyes

Neurological

- Headaches
- Weakness
- Clumsiness

Psychiatric/Emotional

- Speech problems
- Anxiety/stress
- Sleeping issues/nightmares
- Depression
- Nail biting/thumb sucking
- Bad temper/breath holding/
jealousy

Blood/Lymph

- Unexplained lumps

Medical Conditions: Has your child ever been diagnosed with any of the following conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Colic | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Joint Dysplasias |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Shingles/Chicken Pox | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> HIV/AIDS/Immune Disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcers |