Pediatric Health History

THIS INFORMATION WILL BE CONTAINED IN THE PATIENT'S CONFIDENTIAL MEDICAL RECORD

Childs Name: ____ Age: ____________________

Today's Date:___________________________ Date of Birth: _______/_______/________ Sex □ M □ F

Mother's name: ____

Telephone (home) (_____) __________________ (work) (_____) ___________________ (cell) (_____) _________________________

Mailing Address____ City & State ___________________ Zip _______________

Father's name ____

Telephone (home) (_____) __________________ (work) (_____) ___________________ (cell) (_____) _________________________

Mailing Address____ City & State ___________________ Zip _______________

With whom does the child live with? (Circle)
Mother Father Both Other (indicate relationship) ______________________

What are the TOP 3 Health concerns for your child?

1)
2)
3)

Pregnancy & Birth

1. Mother's age at birth ________
2. Did mother have any illness during pregnancy?
   No Yes
3. Did she take any medications other than vitamins & iron?
   No Yes
4. Where was the baby born?
   Hospital Home Birth Center
5. Was the baby on time?
   No Yes
6. What was the birth weight? _______
7. Did the baby have any trouble starting to breathe?
   No Yes
8. Did the baby have any trouble while in the hospital? (jaundice, infections, other)
   No Yes
   What kind?____

Past Medical History

1. Where has your child gone for check-ups until now?
   ____
2. Date of last checkup: ____
3. Date of last dental check-up: __________________________________
4. Has your child had allergic reactions to any medications, foods, insect bites?
   No Yes
   Please describe:____
   ____
5. Has your child had reactions to any immunizations?
   No Yes
   Which ones?____
6. Any hospitalization other than for birth?
   No Yes
   For what? ____
7. Any serious injuries?
   No Yes
   What kind? ____
8. Are any medications taken regularly?
   No Yes
   Which ones? ____
9. When was the child last on antibiotics? Which one and for what?
   ____
   ____
9. Other comments about past medical history?

Family History:

1. Are the child's parents both in good health?
   No Yes
2. Circle any diseases that this child's parents, grandparents brothers, sisters or aunts and uncles have had: **anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others:**
   ____
   ____
3. List name, age, sex and general health of brothers and sisters:
   ____
   ____

FEEDING AND NUTRITION:

1. Is your child's appetite usually good?
   No Yes
2. Is it good now?
   No Yes
3. Was there severe colic or any unusual feeding problem during the first 3 months?
   No Yes
4. Do any foods disagree with him/her?
   No Yes Which ones? ________________________

____
5. For the first 6 months, is he/she (was he/she) breast fed or bottle fed?____________________________
6. If still on formula, which one do you use?
   ____
7. Does he/she take vitamins, supplements and/or herbs?
   No Yes
   Which ones?____

____
8. Are there any particular diet regimens or restrictions?

____

REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections?
   No Yes
2. Any eye problems?
   No Yes
3. Has he/she had any problems with teeth?
   No Yes
4. Does he/she have frequent colds or sore throats?
   No Yes
5. Is there asthma, pneumonia, or recurrent cough?
   No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination?
   No Yes
8. Any problems with diarrhea or constipation?
   No Yes
9. Have there been any convulsions or other problems with the nervous system?
   No Yes
10. Any eczema, hives, or other skin conditions?
    No Yes
11. Has your child ever been anemic?
    No Yes
12. Has your child had chicken pox?
    No Yes
13. Please list any other medical problems:________________________
    ____
    ____

DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone?______________
2. At what age did he/she walk alone?______________
3. Did he/she say any words by the time he/she was 1 ½ years old? No Yes
4. How does this child compare to others his or her age?
   ____
5. Does he or she have any trouble sleeping?
   No Yes
6. What grade is he/she in?______________________
7. Has he/she had any trouble in school?
   No Yes
8. Does he/she get along with other children?
   No Yes
9. Circle if your child has had any of the following: **nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others:**____

SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home or other? (Circle one)
2. Do you know the hottest temperature of water in your pipes? No Yes
3. Is there a working smoke alarm on each floor of the house? No Yes
4. Does your child always use a seat/seatbelt when riding in a car?
   No Yes
5. Are there any smokers in the household?
   No Yes
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice)
   No Yes
7. Does your child always wear a helmet when riding his/her bicycle? No Yes

H. Do you have a record of vaccinations your child has received?
   No Yes
   If yes, please provide a copy of vaccination record

Additional health history:

____
____
____

Parent/Guardian Signature: ____

Reviewed with patient/parent/guardian, by____Date:____________

Physician Signature