



## Pediatric Health History Form

Your relationship to child: \_\_\_\_\_

Child's previous doctor/primary care provider: \_\_\_\_\_

Present health concerns: \_\_\_\_\_

Medicines/Vitamins:

Herbs/Home Remedies:

Allergies/Reactions to medicines or vaccinations:

### PREGNANCY & BIRTH

Where was your child born? \_\_\_\_\_

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: \_\_\_\_\_

APGAR score 1 min. \_\_\_\_\_ 5 min. \_\_\_\_\_

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:

Milk intake now: Type  Cow's milk ( Nonfat  
 1% fat  2% fat  Whole)  
 Soy milk  Rice milk

Average ounces per day (Note: 8 ounces = 1 cup)

### PATIENT LABEL

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

AGE: \_\_\_\_\_

### SLEEP

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 any of the following diseases:

- Chickenpox  Measles  Mumps  
 Rubella  Meningitis  Tuberculosis (TB)

### EXPOSURE/HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint)  No  Yes

Do any household members smoke?  No  Yes

TV – hours per day \_\_\_\_\_

Computers – hours per day \_\_\_\_\_

Video games – hours per day \_\_\_\_\_

### PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalization/operations (with dates):

\_\_\_\_\_

Broken bones or severe sprains:

\_\_\_\_\_

**FAMILY HISTORY**

Please indicate any deaths of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism \_\_\_\_\_

High cholesterol \_\_\_\_\_

Cancer, specify type \_\_\_\_\_

High blood pressure \_\_\_\_\_

Heart disease \_\_\_\_\_

Stroke \_\_\_\_\_

Depression/suicide \_\_\_\_\_

Bleeding or clotting disorder \_\_\_\_\_

Genetic disorders \_\_\_\_\_

Asthma/COPD \_\_\_\_\_

Diabetes \_\_\_\_\_

Other: \_\_\_\_\_

**SOCIAL HISTORY**

Who lives at home?

Name	Age	Relationship	Highest Education Level
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are your child's parents  Married  Unmarried

Separated  Divorced

If divorced or separated, when? \_\_\_\_\_

Mother's Occupation \_\_\_\_\_

Mother's Employer \_\_\_\_\_

Father's Occupation \_\_\_\_\_

Father's Employer \_\_\_\_\_

Child care situation  Parents  Others (specify who and how often) \_\_\_\_\_

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 school or preschool?

No  Yes

Current grade \_\_\_\_\_

Name of school \_\_\_\_\_

Any concerns about school performance?

\_\_\_\_\_

Any concerns about relationship with:

Teachers  No  Yes

Peers  No  Yes

If more than 4 years old: does your child have a best friend?  No  Yes

Sports/exercise: Type \_\_\_\_\_

How often? \_\_\_\_\_

How long (minutes)? \_\_\_\_\_

**REVIEW OF SYMPTOMS:** Please check any current problems your child has on the list below:

*General*

- \_\_\_ Fevers/chills/excessive sweating
- \_\_\_ Unexplained weight loss/gain

*Genitourinary*

- \_\_\_ Bedwetting
- \_\_\_ Pain with urination
- \_\_\_ Discharge: penis or vagina

*Eyes*

- \_\_\_ Squinting/"crossed" eyes/asymmetric gaze

*Musculoskeletal*

- \_\_\_ Muscle/joint pain

*Skin*

- \_\_\_ Rashes
- \_\_\_ Unusual moles

*Ears/Nose/Throat*

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

*Allergy*

- \_\_\_ Hay fever/itchy eyes

*Neurological*

- \_\_\_ Headaches
- \_\_\_ Weakness
- \_\_\_ Clumsiness

*Cardiovascular*

- \_\_\_ Tires easily with exertion
- \_\_\_ Shortness of breath
- \_\_\_ Fainting

*Psychiatric/Emotional*

- \_\_\_ Speech problems
- \_\_\_ Anxiety/stress
- \_\_\_ Sleep issues
- \_\_\_ Depression
- \_\_\_ Nail biting/thumb sucking
- \_\_\_ Bad temper/breath holding/jealousy

*Respiratory*

- \_\_\_ Cough/wheeze
- \_\_\_ Chest pain

*Gastrointestinal*

- \_\_\_ Nausea/vomiting/diarrhea
- \_\_\_ Constipation
- \_\_\_ Blood in bowel movement

*Blood/Lymph*

- \_\_\_ Unexplained lumps
- \_\_\_ Easy bruising/bleeding