

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

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 milk)  Soy milk  Rice milk

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

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:  Chickenpox  Measles  Mumps  Rubella  Meningitis  Tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/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 indicate with a check ( ✓ ) family members who have had any of the following conditions:

Medical Condition	Admin use only	Mom 1	Dad 2	Sister 3	Brother 4	Mom's Mom 5	Mom's Dad 6	Dad's Mom 7	Dad's Dad 8	Mom's Sister 12	Mom's Brother 13	Dad's Sister 14	Dad's Brother 15
Alcoholism	33												
Anemia	1												
Asthma	5												
Autoimmune Disorder	34												
Bleeding Problem	7												
Cancer, Breast	8												
Cancer, Melanoma	10												
Cancer, Ovary	11												
Congenital Anomaly/Birth Defect	36												
Heart Attack/Heart Disease	13												
Depression	14												
Diabetes, on insulin shots	37												
Diabetes, not on insulin	38												
Eczema	17												
Food Allergy	39												
Genetic Disorder	19												
Hay Fever	20												
Hearing Disorder	21												
High Cholesterol	22												
High Blood Pressure	23												
Immune Disorder	24												
Kidney Disease	25												
Mental Retardation or Learning Disability	40												
Stroke	28												
Substance Abuse	43												
Thyroid Disorders	30												
Tobacco Use	30.5												
Tuberculosis	31												
Death before age 56 for reason not listed above													
Other:													
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 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 school or preschool?  No  Yes

Current grade \_\_\_\_\_ Name of school \_\_\_\_\_

Any concerns about school performance? \_\_\_\_\_

Any concerns about relationship with: Teachers  No  Yes

Students  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:

### *Constitutional*

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

### *Eyes*

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

### *Ears/Nose/Throat*

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

### *Cardiovascular*

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

### *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

### *Allergy*

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

### *Neurological*

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

### *Psychiatric/Emotional*

- \_\_\_ Speech problems
- \_\_\_ Anxiety/stress
- \_\_\_ Problems with sleep/nightmares
- \_\_\_ Depression
- \_\_\_ Nail biting/thumb sucking
- \_\_\_ Bad temper/breath holding/  
jealousy

### *Blood/Lymph*

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