



Keeping your child healthy  
is our #1 priority



## PEDIATRIC HEALTH HISTORY

Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated confidentially.

Date \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_

Child's Name \_\_\_\_\_  M  F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_

E-mail \_\_\_\_\_ Phone: Cell #1 (\_\_\_\_\_) \_\_\_\_\_ Cell #2 (\_\_\_\_\_) \_\_\_\_\_

Child's School \_\_\_\_\_ Grade \_\_\_\_\_

Previous Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

### ALLERGIES

Substance	Reaction
_____	_____
_____	_____
_____	_____

### MEDICATIONS

Medication Name	Dosage
_____	_____
_____	_____
_____	_____

## MEDICAL HISTORY

Please check  if child has ever had any of the following:

- Anemia
- Asthma
- Bronchitis/Bronchiolitis
- Bronchopulmonary Dysplasia (BPD)
- Chicken Pox
- Hepatitis
- Immune Deficiency/HIV
- Measles (10-day)
- Measles, Rubella (3-day)
- Mumps
- Prematurity
- Rheumatic fever
- Pneumonia
- Sickle Cell Disease
- Whooping cough
- Other \_\_\_\_\_

#### GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Forgetfulness
- Headache
- Loss of sleep
- Mood swings
- Nervousness

- Numbness
- Sweating
- Tiredness
- Weight loss/gain

#### CARDIOVASCULAR

- Breathing problems
- Chest pain
- Irregular heart beat

#### EYES

- Crossed or wandering eyes
- Eye irritation
- Headaches
- Vision problems

#### HEARING/SPEECH

- Difficulty hearing
- Earache
- Ear infections
- Hoarseness
- Speech problems \_\_\_\_\_

#### DENTAL

- Bleeding gums
- Grinding teeth
- Sensitivity to hot/cold
- Thumb-sucking
- Last dental check-up  
Date \_\_\_\_\_

- Brush, how often? \_\_\_\_\_

- Floss, how often? \_\_\_\_\_
- Pain, weakness, swelling in:

#### GASTROINTESTINAL

- Appetite poor
- Bloody or dark stools
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Nausea
- Rectal bleeding
- Stomachaches
- Vomiting
- Worms

#### GENITO-URINARY

- Bed-wetting
- Blood in urine
- Diaper rash, persistent
- Discharge from vagina or penis
- Frequent urination
- Painful urination
- Unusual urine odor

#### MUSCLE/JOINT/BONE:

- Broken bones or sprains
- Coordination problems
- Posture problems

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

#### NOSE/THROAT/CHEST

- Difficulty breathing
- Difficulty swallowing
- Frequent colds
- Hoarseness
- Mouth-breathing
- Nosebleeds
- Persistent cough
- Sinus problems
- Sore throats
- Strep throat
- Tonsil infections
- Wheezing

#### SKIN

- Bruise easily
- Change in moles
- Hives
- Itching
- Rash
- Scars
- Sores that won't heal

# DIETARY ASSESSMENT

How often does your child eat the following:

	3 Times Daily	Daily	Weekly	Monthly
Beans, peas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breads, cereals, grains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poultry, fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sodas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables, green	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables, yellow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



What vitamin supplements does your child take? \_\_\_\_\_ How often? \_\_\_\_\_  
 Is there fluoride in your water?  Yes  No

## HOSPITALIZATIONS

Reason	Date	Hospital, City, State

## INJURIES

Serious Injuries/Illnesses	Date	Outcome

Has your child ever had a blood transfusion?  Yes  No

## IMMUNIZATIONS

Please check  whether or not your child has been given the following immunizations. If yes, please fill in the date(s) given.

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	Polio shots, series of 3	<input type="checkbox"/>	<input type="checkbox"/>	_____	Measles Vaccine
<input type="checkbox"/>	<input type="checkbox"/>	_____	DPT, series of 3 shots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Polio booster shots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mumps Vaccine
<input type="checkbox"/>	<input type="checkbox"/>	_____	DPT booster shots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Polio by mouth, series of 3	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rubella Vaccine
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hib (Influenza)	<input type="checkbox"/>	<input type="checkbox"/>	_____	PCV7 (Pneumococcal)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chicken Pox Vaccine

## FAMILY HISTORY

Please give the following information about your child's immediate family:

Age	General Health	Age	General Health
Father _____	_____	Sibling _____	_____ <input type="checkbox"/> M <input type="checkbox"/> F
Mother _____	_____	Sibling _____	_____ <input type="checkbox"/> M <input type="checkbox"/> F
Have any of your children died? <input type="checkbox"/> Yes <input type="checkbox"/> No		Sibling _____	_____ <input type="checkbox"/> M <input type="checkbox"/> F

Please check  conditions that any of the child's blood relatives (including parents and siblings) have had and the relationship to the child:

Condition	Relationship	Condition	Relationship
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> HIV/AIDS	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Lung disease	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Mental disease/disorder	_____
<input type="checkbox"/> Asthma/emphysema	_____	<input type="checkbox"/> Mental retardation	_____
<input type="checkbox"/> Birth defects	_____	<input type="checkbox"/> Muscle disorders	_____
<input type="checkbox"/> Bone/joint disorders	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Seizures/convulsions	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Sickle cell anemia	_____
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Skin disease	_____
<input type="checkbox"/> Eye or ear disorders/Hearing loss/Blindness	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Genetic defects	_____	<input type="checkbox"/> Thyroid disease	_____
<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Hemophilia	_____	<input type="checkbox"/> Venereal disease	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Other	_____

# PRE-NATAL AND INFANT HEALTH HISTORY

Place of birth \_\_\_\_\_ Obstetrician \_\_\_\_\_ Mother's age at birth \_\_\_\_\_

**During the pregnancy which conditions did you have? Please  all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol use  | <input type="checkbox"/> Exposure to chemical or radiation   |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Fever                               |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> German measles                      |
| <input type="checkbox"/> Drug use, non-prescription drugs (Please list) _____             | <input type="checkbox"/> Hepatitis                           |
| _____   | <input type="checkbox"/> High blood pressure                 |
| <input type="checkbox"/> Drug use, prescription drugs (Please list) _____                 | <input type="checkbox"/> Protein in urine                    |
| _____   | <input type="checkbox"/> Tobacco use                         |
| <input type="checkbox"/> Drug use, controlled drugs such as narcotics (Please list) _____ | <input type="checkbox"/> Urinary tract infection             |
| _____   | <input type="checkbox"/> Venereal disease                    |
| <input type="checkbox"/> Edema (Swelling)   | <input type="checkbox"/> Other illnesses or infections _____ |

**DELIVERY** Please check  all that apply:

- On time     Premature     Late     Normal     Induced     Prolonged     Breech     C-Section

Please describe \_\_\_\_\_

## INFANT HEALTH

Birthweight \_\_\_\_\_ Length \_\_\_\_\_  
 Discharge weight \_\_\_\_\_ Age when discharged \_\_\_\_\_

**INFANT HEALTH PROBLEMS** Please check  and describe.

- Birth defects \_\_\_\_\_  
 Breathing problems \_\_\_\_\_  
 Infection \_\_\_\_\_  
 Jaundice \_\_\_\_\_  
 Transfusion \_\_\_\_\_  
 Other \_\_\_\_\_

## FEEDING

- Breast fed     Formula fed

## DEVELOPMENTAL

 Please note age at which your child:

- Lifted head \_\_\_\_\_ Wk.  
 Rolled over \_\_\_\_\_ Mo.  
 Cooed/Laughed \_\_\_\_\_ Mo.  
 Sat up \_\_\_\_\_ Mo.  
 Stood up \_\_\_\_\_ Mo.  
 Walked \_\_\_\_\_ Mo.  
 Finger fed \_\_\_\_\_ Mo.  
 Drank from cup \_\_\_\_\_ Mo.  
 Spoon fed \_\_\_\_\_ Mo.  
 First word \_\_\_\_\_ Mo.  
 Toilet trained \_\_\_\_\_ Mo.  
 Dressed self \_\_\_\_\_ Mo.



# EDUCATION AND SOCIAL HISTORY

**Please explain any problems or concerns you have about your child in any of the following areas:**

Appearance/Weight/Height \_\_\_\_\_

Behavior \_\_\_\_\_

Friends \_\_\_\_\_

Grades/learning ability \_\_\_\_\_

Sexuality \_\_\_\_\_

How many hours per day does your child watch television or play video games? \_\_\_\_\_ Get exercise? \_\_\_\_\_

Do you suspect that your child is involved with:  Drugs     Alcohol     Tobacco     None

**Have you noticed any of the following warning signs of drug abuse:**

- |                        |  |                                   |  |
|------------------------|--|-----------------------------------|--|
| Angry behavior         | <input type="checkbox"/> No <input type="checkbox"/> Yes | Depression                        | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Changes in appearance  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Signs of drugs in the house       | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Changes in attitude    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Skipping school                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Changes in friendships | <input type="checkbox"/> No <input type="checkbox"/> Yes | Withdrawal from friends or family | <input type="checkbox"/> No <input type="checkbox"/> Yes |

# CHILD SAFETY INVENTORY

Adequate number of working smoke alarms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Safety plugs in unused wall sockets?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does child use car seat/seat belt?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Safety gate for stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicines, cleaning supplies, chemicals out of reach?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Know dangers of peeling paint, mice/rats in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Syrup of Ipecac in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does child know how to swim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Know poison control phone number?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are guns in the home in locked storage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Water heater set below 120°F?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does child use bicycle helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PARENT CONCERNS** Reason for visit today and any other concerns or questions you have about your child.

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To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Signature of Parent, Guardian or Personal Representative	Date
Please print name of Parent, Guardian or Personal Representative	Relationship to Patient

**DR. COMMENTS**

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Physician Signature	Date
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**UPDATES** (To be filled in at future appointments)

Has there been any change in child's health since last appointment?  Yes  No

Please describe \_\_\_\_\_

Parent/Guardian Signature	Date	Physician Signature	Date
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Has there been any change in child's health since last appointment?  Yes  No

Please describe \_\_\_\_\_

Parent/Guardian Signature	Date	Physician Signature	Date
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Has there been any change in child's health since last appointment?  Yes  No

Please describe \_\_\_\_\_

Parent/Guardian Signature	Date	Physician Signature	Date
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