Pediatric Health History Form

Child's Name______________________________ **Date of Birth**___________________________

Mother's Name ___________________________ **Father's Name** ___________________________

Parent Concerns - Please explain any other concerns or questions you have about your child

____
____
____

Does your child have any allergies? Yes NO

If yes please list below

____ ____

____ ____

____ ____

Does your child take any medications / vitamins / over the counter supplements or herbs? Yes NO

If yes please list below

____ ____

____ ____

____ ____

Has your child received any immunizations? Yes NO

If yes please provide an immunization record.

Educational and Social History

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

Appearance/Weight/Height____

Behavior____

Grades/learning ability____

Sexuality____

Friends____

How many hours per day does your child watch television, surf the internet (not counting homework time) or play video games_______________________________________

Hours per day of exercise_______________________________________

Hours per day of extracurricular activities_________________________

Please describe any spiritual or religious preferences_____________________________________

Are there any objections or preferences to medical treatments (i.e prefer homeopathy, prefer not to immunize, etc.)?____

Please list all those living in the child's home.

Name	Relationship to child	Date of birth	Health status

Are there siblings not listed? If so, please list their names, ages, and where they live.

____

____

What is the child's living situation if not with both biological parents?___ Lives with adoptive parents ___ Joint custody ___ Single custody ___ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home

____

Mother's occupation____

Father's occupation____

Childcare situation____

Prenatal and Infant Health History

Place of Birth_________________________________ Maternal age ____ Paternal age____

Birth weight ________________ Length ___________________ Head circumference ________________

Was the baby born at term? Yes OR weeks __________

Were there any prenatal or neonatal complications? Yes No Explain________________________

Was a NICU stay required? Yes No Explain____

During pregnancy, did mother

Use tobacco Yes No Drink alcohol Yes No

Use drugs or medications Yes No Use prenatal vitamins Yes No

Explain____

Was the delivery Vaginal Cesarean If cesarean, why? ______________________________________

Was initial feeding

Formula

Breast milk How long breastfed?__________________________________

Did your baby go home with mother from the hospital? Yes No Explain_______________________

Developmental History (Please note age at which your child)

Walked_________________ Rolled over___________________ Crawled____________________

First Word_______________ Dressed self__________________ Drank from cup______________

Toilet trained_____________

General DK = Don't Know

	Yes	No	DK	Explain
Do you consider your child to be in good health				
Does your child have any serious illnesses or medical conditions				
Do you feel your family has enough to eat				
Does your child drink caffeine				
Is there a swimming pool at home				
Any smokers at home				
Are there smoke detectors at home				
Carbon Monoxide detectors				
Any pets at home				
What is your water source				
Are guns kept in your home				
Do all family members use Seat belts/care safety sets				
Do all family members use Helmets when biking				
Has your child been to a dentist in the past year				
Has your child been to an eye doctor				

Past Medical History

Has your child ever had,

Item	Yes	No	Don't know	Explain
Chicken pox				Date
Frequent ear infections				
Problems with hearing				
Nasal Allergies				
Problems with eyes or vision?				
Asthma				
Bronchitis / bronchiolitis / pneumonia				
Heart problems or murmur				
Anemia or bleeding problem				
HIV				
Organ transplant				
Cancer				
Frequent abdominal pain				
Constipation				
Urinary tract infections				
Bed wetting past 6 years of age				
Kidney disease				
Heart disease				
High blood pressure				
Thyroid disease				
Sleep problems including snoring				
Skin problems				
Frequent headaches				
Concussion(s)				
Seizures				
Developmental delay				
Behavior problems				
School performance concerns				
Drug / alcohol use				
For girls – problems with period / age of menarche				
Broken bone(s)				
Hospitalizations				
Surgeries				

Review of Symptoms

Please check the box if your child is currently experiencing any of the following:

General
- Fatigue
- Fever
- Chills
- Weight loss/gain

Eyes
- Discharge
- Eye discomfort
- Changes in vision
- Crossed/Wandering eye

Ears / Nose / Throat
- Headache
- Difficulty hearing
- Recurrent ear infections
- Chronic nasal congestion / drainage
- Snoring
- Recurrent sinus infection
- Recurrent Sore throats
- Nosebleeds

Heart
- Fainting
- Chest Pain
- Irregular heart beat

Respiratory
- Wheezing
- Cough
- Poor exercise tolerance
- Restless sleep

Stomach
- Vomiting
- Diarrhea
- Constipation
- Recurrent stomach aches
- Poor appetite
- Excessive hunger/thirst

Genital - Urine
- Bed-wetting
- Blood in urine
- Frequent urination
- Painful urination
- Discharge from Vagina/penis

Musculoskeletal
- Joint pain
- Joint swelling
- Muscle weakness
- Muscle pain

Neurologic
- Seizure
- Developmental delay
- Poor coordination

Skin
- Acne
- Change in moles
- New moles / skin lesions
- Hives
- Rash
- Easy bruising

Endocrine
- Loss of hair
- Heat or cold intolerance
- Poor growth
- Pubertal changes

Psychiatric
- Depression
- School difficulties
- Inattention
- Hyperactivity
- Behavior issues

Family Medical History: Have any family members had the following?

Item	Yes	No	Don't know	Who	Comments
Childhood hearing loss					
Allergies					
Asthma					
Heart disease (before 55 years of age)					
High cholesterol					
Bleeding disorder					
Cancer (before 55 years of age)					
Liver disease					
Kidney disease					
Obesity					
Diabetes					
Developmental delay					
Seizures / neurological disorder					
Mental illness / depression					
Substance abuse					
Eating disorder					
Immune problems					
Additional family history					

I have answered the questions on this form to the best of my knowledge. I understand that to provide incorrect or incomplete information about my child's health and symptoms could place my child's health at risk.

Parent/Guardian Signiature____Date__________________