Suburban Healthcare Associates

Pediatric Health History Form

Child's Name: ____________________ Birthdate: __________ Today's Date: _________

Child's Previous Doctor: ____

Child's Dentist: ___________________________________ Regular Visits? Yes No

Your Regular Pharmacy (Name/Street): ____

Current Problems/Concerns:

____

____

Allergies/Reactions to Medicines, Foods, or Environment (Please list nature of reaction):

____

Current Medicines:

____

Pregnancy & Birth:

Were there any problems with the pregnancy?

____No ____Yes (please specify): ___________________________________

Was the baby full term _________ or premature? _________ If so, how early? ____________

Delivered by: ____vaginal birth ____caesarian (please explain why): ________________

Birth weight: ___________________ Birth length: __________________

Delivery Hospital: ______________________________ Your Ob: _____________________

Past Medical History:

Has your child had any of the following conditions? Please circle all that apply:

Asthma/Hay Fever/Eczema	RSV/Bronchiolitis	Pneumonia
Attention/Learning problems	Seizures/Convulsions	Developmental delays
Broken bones/Major injuries	Anemia/Bleeding Problems	Urinary Tract Infections
Heart problem or Murmur	Chicken pox	Other
Frequent Ear Infections	Frequent Strep Infections	______________________

Past Surgical History:

Has your child had any operations such as ear tubes, hernia repair, or tonsillectomy?

___________No ___________Yes (Please explain – type of surgery, location, dates):

____

Immunizations: ***Please bring your child's shot record.***
Are your child's immunizations up to date? ____Yes ____No

Social History / Safety Issues:
The child's parents are: ____married ____single
____divorced ____other (specify) ___________________

Does your child attend daycare during the day or after school? ____Yes ____No

Do any household members smoke? ____Yes ____No

Any concerns about lead exposure? (Old home/plumbing/peeling paint) ____Yes ____No
Has your child had a previous lead test? If so, was it normal or low? ____Yes ____No

Does your child attend preschool/school? ____Yes ____No Grade: ___________
Name of School: ____
Any concerns about school performance? ____Yes ____No
(Specify): ____

Are there any pets in your home? ____Yes ____No (Specify): ____________________

Family History:
Please circle any family history of the following and indicate who has/had the condition (mother, father, brother, sister, maternal/paternal grandparent, extended family):

Alcoholism/drug abuse	Yes/No_____________________________
Attention Deficit Hyperactivity Disorder	Yes/No_____________________________
Asthma/hay fever/eczema	Yes/No_____________________________
Bleeding/clotting problems	Yes/No_____________________________
Cancer	Yes/No_____________________________
Diabetes	Yes/No_____________________________
Heart Disease/Attack before age 50	Yes/No_____________________________
Hearing Loss/Deafness	Yes/No_____________________________
High Blood Pressure	Yes/No_____________________________
High Cholesterol	Yes/No_____________________________
Hip Problems/Dislocations	Yes/No_____________________________
Inherited/Genetic diseases/Birth Defects	Yes/No_____________________________
Kidney Disease	Yes/No_____________________________
Learning Disabilities	Yes/No_____________________________
Mental Illness/Anxiety/Depression	Yes/No_____________________________
Seizures	Yes/No_____________________________
Sudden unexplained death before age 50	Yes/No_____________________________
Thyroid Disease	Yes/No_____________________________
Other (please explain)	Yes/No_____________________________

Thank you for taking the time to fill out this form. It will be reviewed by the physician and will become part of your record.

Parent Signature ____________________________ Date _________________

Doctor's Signature __________________________ Date _________________