

Pediatric Health History

(0 – 15 year)

Name: _____ DOB: ____/____/____ Sex: M F

Person completing form & relationship: _____

Check all items that apply to your child and fill in blanks as needed.

Newborn to 3 months (fill in this section only now; additional history to be completed later):

Mother's age at pregnancy? _____ yrs. Medications during pregnancy? _____

Any illness during pregnancy? Yes, explain _____ No

Did mother smoke, use street drugs or alcohol during pregnancy? Yes, explain _____ No

Was baby: Full term or Premature, _____ wks. Type of delivery: Vaginal C-section

Birth weight: _____ lbs. _____ oz. Length: _____ in. Apgar rating: _____

Complications for mother or child during labor, delivery or newborn period: _____

Did child receive 2 newborn screens (heel sticks) before 2 weeks of age? Yes No Unknown

Did newborn receive a hepatitis B shot in the hospital? Yes No Unknown Hospital _____

Past Medical History:

- | | |
|---|---|
| <input type="checkbox"/> Allergies (other than drugs), _____ | <input type="checkbox"/> Heart problems or murmur |
| <input type="checkbox"/> Anemia or Blood problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypothyroid or Hyperthyroid |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Inherited disease |
| <input type="checkbox"/> Blood transfusion, what year _____ | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Cancer/Tumor, explain _____ | <input type="checkbox"/> Learning disability, type _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Depression or suicide attempts | <input type="checkbox"/> Measles, German Measles or Mumps |
| <input type="checkbox"/> Diabetes, type _____, how long _____ | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Drug or Alcohol abuse | <input type="checkbox"/> Rheumatic or scarlet ever |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually transmitted disease (STD) |
| <input type="checkbox"/> Eating disorder, bulimia or anorexia | <input type="checkbox"/> Sickle cell anemia or trait |
| <input type="checkbox"/> Eczema or psoriasis | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Headaches, type _____ | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing loss or deafness | <input type="checkbox"/> Other _____ |

Past Surgical and Hospitalization History:

- | | |
|---|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Psychiatric treatment, inpatient or outpatient |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Fracture, _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hernia, R or L, type _____ | <input type="checkbox"/> Other: _____ |

(Turn page over for more questions)

Females Only: Age at first period: _____ yrs. old Date of last period: _____
 Number of: Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
 Birth control method: _____ Date of last Pap smear: _____

Drug allergies: No Known Drug Allergies
Name of Drug Reaction

Current Medications: (prescription, over-the-counter, herbs, vitamins, fluoride):

<u>Medication</u>	<u>Strength/Dose</u>	<u>Frequency</u>	<u>Medication</u>	<u>Strength/Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Immunizations: Are your child's immunizations up-to-date? Yes No
If not available today, please provide a copy of your child's immunization record by the next visit.

Social History:

Parents: Married Divorced, if divorced, who does child live with: _____
 How is child doing in school? Good Fair Poor In special classes: Yes No
 Tobacco: Cigarettes Chew/snuff How much/day _____; how long _____; Quit, when _____
 Alcohol: Number of drinks or bottles of beer per week: _____
 Caffeine: Number of cups of coffee _____/day, glasses of tea _____/day, sodas _____/day
 Sexually active: Yes No New partner in the last year? Yes No
 Victim of Abuse: physical sexual mental verbal Who is / was abuser? _____
 Infant car seat, toddler seat or seat belt restraint used regularly: Yes No, why? _____
 Firearms (guns or rifles) in home: Yes No Under lock and key: Yes No
 Exposure to hazardous materials or lead? _____
 Special diet or vegetarian? _____ Travel to foreign countries? _____
 Death in family in the last year? Yes No Relationship _____
 Cigarette or cigar smokers in the home? Yes No
 Members of household (list): _____

Family History:

	Living		Deceased	
	<u>Age</u>	<u>Health status or illnesses</u>	<u>Age</u>	<u>Cause of death & illnesses</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Father's father	_____	_____	_____	_____
Father's mother	_____	_____	_____	_____
Mother's father	_____	_____	_____	_____
Mother's mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

Parent or Guardian Signature: _____ Date: ____/____/____

Provider review: Signature: _____ Date: ____/____/____