

PEDIATRIC HEALTH HISTORY FORM

Patient Name _____ DOB: ____/____/____

Parent/Guardian Name _____ Date: ____/____/____ Relationship: _____

Present Health Concerns: _____

MEDICATIONS: Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc.

Medication Name	Dose	Frequency

ALLERGIES: List all reactions to medicines, foods and other agents.

Allergy	Reaction or Side Effect

* If the patient is taking 3 or more medications please bring them with you to each appointment.

PERSONAL MEDICAL HISTORY: Please indicate whether the patient has had any of the following medical problems.

- | | | |
|--------------------------|----------------------|---------------------------|
| Asthma/Wheezing | Heart Disease/Murmer | Vision Problems |
| Anemia/ Bleeding Problem | Ear Infections | Environmental Allergy |
| Pneumonia | Convulsions/Epilepsy | Bladder/Kidney Infections |
| Diarrhea | Constipation | Skin Problems |
| Hearing Problems | Headache | Diabetes |
| | | Other _____ |

HOSPITALIZATIONS: Please list all prior hospitalizations/serious illnesses and dates.

Reason for hospitalization	Date

IMMUNIZATIONS: Please attach a list or list immunization dates that the patient has received at other health care facilities.

Hepatitis A: _____ DTaP: _____ Polio: _____ Pevnar: _____ MMR: _____
 Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Menactra: _____
 HIB : _____ HPV : _____ Other: _____

COMMUNICABLE DISEASES: Has your child ever had any of the following infectious disease(s)?

- | | | | |
|------------|---------|---------|-------------------|
| Chickenpox | Measles | Mumps | Meningitis |
| Covid 19 | RSV | Rubella | Tuberculosis (TB) |

PREGNANCY & BIRTH:

Is the child yours by: Birth Adoption Stepchild Other: _____

Method of Delivery: Vaginal Caesarean

Hospital of Birth: _____

Were there any medical problems during pregnancy? Yes No

If yes, please explain: _____

Maternal smoking Alcohol Drugs Medications

Were there any problems during labor and delivery? Yes No

If yes, please explain: _____

After the baby's birth, were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), infection etc? Yes No

If yes, please explain: _____

Birth weight/length: _____ lbs _____ oz _____ inches

Was your child born prematurely? Yes No If yes how early? _____

SLEEP:

Hours per night: _____ How many naps per day: _____

Does your child have any sleep problems? Yes No

If yes, please explain: _____

NUTRITION & FEEDING:

Type of feeding as newborn/infancy: Formula Breastfed If breastfed, for how long? _____

Has your child had any feeding/dietary problems or restrictions? Yes No

If yes, please explain: _____

Milk intake now: Soy Milk Rice Milk Cow's Milk (_____%) Other, please specify: _____

Ounces per day: _____

Has your child seen a dentist? Yes No If yes, date the last visit: _____

What is the water source at the house? City Well

Does your child use a bottle? Yes No Pacifier? Yes No

DEVELOPMENT (May skip this section if child is older than age 12):

At what age did your child: Sit Alone _____ Walk Alone _____ Say Words _____ Toilet Trained (Daytime) _____

Dry at Night _____

Any concerns about growth or progress with rolling over, walking, riding a tricycle, dressing themselves, or feeding themselves? Yes No

If yes, please explain: _____

Any concerns about language or speech development? Yes No

If yes, please explain: _____

In the car, does your child use: Infant seat Booster Seat Seatbelt Only

Does your child wear a helmet while riding a bike? Yes No

Do you have concerns about your child's behavior at home or in groups with other children? Yes No

If yes, please explain: _____

For Female Patients Only: Age at first menstrual period: _____

