

## PEDIATRIC HEALTH HISTORY FORM

Patient Name			_ DOB:					
Parent/Guardian N	ame		_ Date:		Rela	tionship:		
Present Health Cor	ncerns:							
	ase list all prescription an home remedies, birth con		ALLERG agents.	<b>IES:</b> List all I	reactions t	to medicines, foods and ot	her	
Medication N	lame Dose	Dose Frequency		Allergy		Reaction or Side Effect		
* If the patient is taking	g 3 or more medications p	lease bring them w	ith you to ea	ch appointm	ent.			
PERSONAL MEDIC	<b>AL HISTORY:</b> Please in	dicate whether the p	oatient has h	ad any of the	following ı	medical problems.		
Asthma/Wheezi	ng	Heart Disease	e/Murmer	Visio	Vision Problems			
Anemia/ Bleedir	ng Problem	Ear Infections	;		Envir	onmental Allergy		
Pneumonia		Convulsions/E	pilepsy		Blad	der/Kidney Infections		
Diarrhea		Constipation			Skin	Problems		
Hearing Problen	าร	Headache			Diab	etes		
					Othe	r		
HOSPITALIZATION	S: Please list all prior hos	pitalizations/serious	illnesses an	d dates.				
Reason for hospitaliz	ation					Date		
IMMUNIZATIONS:	Please attach a list or list	immunization dates	that the pati	ent has recei	ved at othe	er health care facilities.		
Hepatitis A:	DTaP:	Polio:		Prevnar:		MMR:		
Hepatitus B:	Pneumovax:	Tdap:		Varicella:		Menactra:		
HIB :	HPV :	Other:						
COMMUNICABLE	<b>DISEASES:</b> Has your ch	ild ever had any of t	he following	infectious dis	ease(s)?			
Chickenpox	Measles	Mumps		Meningitis				
Covid 19	RSV	Rubella		Tuberculosis	(TB)			

PREGNANCY & BI	RTH:								
Is the child yours by:	Birth	Adoption	Stepchild		Other:				
Method of Delivery:	Vaginal	Caesarean							
Hospital of Birth:				_					
Were there any medica	al problems d	uring pregnancy?	Yes	No					
If yes, please explain: _									
Maternal smoking	g A	Alcohol [	Orugs	Medicatio	ons				
Were there any proble	ms during lab	or and delivery?	Yes	No					
If yes, please explain: _								<del></del>	
After the baby's birth, w	ere there any	problems such as	needing oxygen,	trouble br	eathing, jaundid	ce (yellowne	ess), infection etc?	Yes	No
If yes, please explain: _								<del></del>	
Birth weight/length: _	lbs	oz	inches						
Was your child born pr	ematurely?	Yes N	lo If yes how e	early?					
SLEEP:									
Hours per night:		How many	naps per day: _						
Does your child have a	ny sleep prol	olems? Yes	No						
If yes, please explain: _									
<b>NUTRITION &amp; FEE</b>	DING:								
Type of feeding as new	born/infancy	r: Formula	Breastfed	If breastf	fed, for how lor	ıg?			
Has your child had any	feeding/diet	ary problems or re							
If yes, please explain: _									
Milk intake now: So	y Milk	Rice Milk	Cow's Milk (_	%	) Other,	please spe	cify:		
Ounces per day:									
Has your child seen a d	dentist?	es No If y	es, date the last	t visit:					
What is the water sour	ce at the hou	ise? City	Well						
Does your child use a l	oottle? Y	es No	Pacifier?	Yes N	No				
DEVELOPMENT (M	lav ekin th	is soction if ch	ild ie aldar tk	an ago	12\.				
At what age did your c	•			•		Toilet Tra	inad (Daytima)		
Dry at Night	illia. Sit Alo	nie vvan	K Alulie	_ Jay vvi	лиз	Tollet II al	inieu (Daytiinie)		
Any concerns about gro	with or progre	ass with rolling ove	r walkina ridina	a triovolo	drossing thom	ealf arfaadi	ing thomsolf?	/es	No
If yes, please explain:		_		-	_	sell, of feedi	ing diemsen:	63	INO
Any concerns about la				No					
If yes, please explain:		•							
In the car, does your cl		Infant seat	Booster Sea		Seatbelt Only				
Does your child wear a			Yes No		ocution only				
Do you have concerns		_		ns with oth	er children?	Yes	No		
If yes, please explain:	-		- '				110		
For Female Patients Or									
TOT TETHATE TALLETIES OF	ny. Ayo at mis	st illelisti dai peliot	۱						

SOCIAL HISTORY:					
Parents are: Married Never Marri	ed Separa	ited Divorced	l If divorced, fo	or how long?	
Mother's Employer:		Mother's Occupation	1:		
Father's Employer:		Father's Occupation:			
Do any household members smoke? Yes	No Is violen	ce in the home a conc	ern? Yes	No	
Are there guns in the home? Yes No					
Would you like to speak with the physician rega	arding your child's:				
Alcohol Use Yes No Tobacco Us	se Yes No	Sexual Activity	Yes No	Mental Health Yes	No
How many hours per day does your child spend	d on the following:				
Watching TV On the Computer/	iPad/Phone	Playing Vide	o Games		
Any concerns about lead exposure due to havi	ng an old home, or b	ecause of plumbing, a	nd peeling paint?	? Yes No	
Smoke detectors in your home? Yes N	lo				
Who lives at the home with the patient?					
Name	Age	Relationship		Highest Level of Educa	tion
SCHOOL HISTORY:					
Did/Does your child attend school/preschool?		ırrent grade in school?			
Which school?					
Do you have concerns with how your child is d	oing in school?	Yes No			
Any concerns about relationships with teacher	s or other students?	Yes No			
If more than 4 years old: does your child have a	best friend? Ye	s No			
Does your child play any sports? Yes	No Which sports	?		Hours per week? _	
Other physical activities: (dance, gymnastics, T	ai Kwan Do):				
Does your child have special needs? (504, IEP, A	Assistive Technolog	y, Paraprofessional):	Yes No		
If yes, please explain:					
FAMILY HISTORY: Indicate with an (X) who		ily has had the followi	ng conditions. In	the first column please	indicate

status. L=Living, D=Deceased, U=Unknown.

	Living Status	Asthma	Diabetes	High Blood Pressure	Stroke/Heart Disease	Hearing Loss	Kidney Disease	Cancer (type)	Drug/Alco- hol Abuse	Depression/ Anxiety	Other (Ge- netic Thyroid)
Mother											
Father											
Siblings											
Maternal Grandmother											
Materal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other											