PEDIATRIC HEALTH HISTORY FORM (one per child)

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 (circle) whether the patient has had any of the following medical problems.

Asthma/Wheezing
Anemia/ Bleeding Problem
Pneumonia
Diarrhea
Hearing Problems
Diabetes
Other ______________

Heart Disease/Murmur
Ear Infections
Convulsions/Epilepsy
Constipation
Headache
Other ______________

Vision Problems
Environmental Allergy
Bladder/Kidney Infections
Skin Problems
Developmental Delay
Other ______________

HOSPITALIZATIONS/OUTPATIENT PROCEDURES: 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: ________ Prevnar: ________ MMR: ________
Hepatitis B: ________ Pneumovax: ________ Tdap: ________ Varicella: ________ Menactra: ________
HIB : ________ HPV : ________ MenQuadfi: ________ 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)

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PREGNANCY & BIRTH:

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

Method of Delivery: Vaginal Caesarean

Hospital of Birth: ______________________________ Country 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

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 themself, feeding themself, or potty training? 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: ____________________

SOCIAL HISTORY:

See Sibling Record

Parents are: Married Never Married Separated Divorced If divorced, for how long? ________________

Mother/Parent #1 Occupation: ______________________________________ Employer: __________________________ Not Employed:

Father/Parent #2 Occupation: ______________________________________ Employer: __________________________ Not Employed:

Child's Primary Language: _________________________________ Other language spoken at home: ______________________________

Lived outside of USA? Yes No Where: __________________________________ How Long: _____________________________

Do any household members smoke? Yes No Is violence in the home of concern? Yes No

Are guns present in the home? Yes No Under LOCK? Yes No

Would you like to speak with the physician regarding your child's:

Alcohol Use Yes No Tobacco Use Yes No Sexual Activity Yes No Mental Health Yes No

How many hours per day does your child spend on:

Watching TV ___________ On the Computer/iPad/Phone _____________ Playing Video Games ______________

Any concerns about lead exposure due to having an old home, or because of plumbing, and peeling paint? Yes No

Smoke detectors in your home? Yes No

Who lives at the home with the patient?

Name	Age	Relationship	Highest Level of Education

SCHOOL HISTORY:

Did/Does your child attend school/preschool? Yes No Current grade in school? _________________

Which school? ____

Do you have concerns with how your child is doing in school? Yes No

Any concerns about relationships with teachers or other students? Yes No

If more than 4 years old: does your child have a best friend? Yes No

Does your child play any sports? Yes No Which sports? _________________________________ Hours per week? _______

Other physical activities: (dance, gymnastics, Tai Kwan Do): ____

Does your child have special needs? (504, IEP, Assistive Technology, Paraprofessional): Yes No

If yes, please explain: ____

FAMILY HISTORY: Indicate with an (X) who in your child's family has had the following conditions.

See Sibling Record

In the first column please indicate living status. L=Living, D=Deceased, U=Unknown.

	Living Status	Asthma	Diabetes	High Blood Pressure	Stroke/Heart Disease	Hearing Loss	Kidney Disease	Cancer (type)	Drug/ Alcohol Abuse	Depression/ Anxiety	Other (Genetic Thyroid)
Mother/Parent 1											
Father/Parent 2											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other											