Pediatric Health History Form (PLEASE PRINT CLEARLY)

Name ________________________________ **Date of Birth** ____/____/_______ **Age** ______

Your relationship to child:_________________________

Child's Primary Care Provider ____

Present Health Concerns: ____

____

____

Medicines/Vitamins____

____

Vaccinations up to date? YES [ ] NO [ ]

PREGNANCY AND BIRTH

Is the child yours by: [ ] Birth [ ] Adoption [ ] Stepchild [ ] Other

Please indicate any medical problems during pregnancy; [ ] None [ ] Specify:

____

Delivery by [ ] Vaginal Birth [ ] Caesarean If Caesarean, why? ______________________

Birth Weight ______ **lbs,** ______ **oz.**

Please indicate any medical problems during the baby's newborn period;

[ ] None [ ] What problems?____

[ ] Premature? How early?__________________________

Other problems: ____

SLEEP **Hours per night ?** _____________**Any Problems?** ____________________

DEVELOPMENT

At what age did your child sit alone?__________ **Walk alone?** _________

Say Words? ______________ **Toilet train (daytime) ?** ________________

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates: __________________________

____

Hospitalizations/surgeries/medical problems (with dates); ______________________________

____

FAMILY HISTORY

Please indicate family members (Parent, Sibling, Paternal/Maternal Grandparent, Aunt or Uncle) with any of the following conditions;

High Blood Pressure____

Heart disease____

Stroke ____

Depression/suicide____

Genetic disorders____

Diabetes____

Migraines ____

ADD/ADHD ____

Seizures ____

Other ____

SOCIAL HISTORY

Who lives at home?

Name	**Age**	**Relationship**	**Highest Educational Level**
____________	____	____________	________
____________	____	____________	________
____________	____	____________	________
____________	____	____________	________
____________	____	____________	________
____________	____	____________	________

Are your child's parents; [ ] Married [ ] Unmarried [ ] Separated [ ] Divorced

If divorced or separated, when?________________________

SCHOOL HISTORY

Did/does your child attend preschool or school? [ ] Yes [ ] No Current Grade: _______

Any concerns about school performance? ______________________________

Any concerns about relationship with:

Teachers [ ] Yes [ ] No Peers [ ] Yes [ ] No

Sports/exercise: Type ______________________________________

REVIEW OF SYMPTOMS: **Please check any current problems your child has on the list below**

General

[ ] Fevers/chills, excessive sweating

[ ] Unexplained weight loss/gain

Eyes

[ ] Squinting/crossed eyes/ asymmetric gaze

Ears/Nose/Throat

[ ] Unusually loud voice/hard of hearing

[ ] Mouth breathing/snoring

[ ] Bad breath

[ ] Frequent runny nose

[ ] Problems with teeth/gums

Respiratory

[ ] Cough/wheeze

[ ] Chest pain

Genitourinary

[ ] Bedwitting

[ ] Pain with urination

[ ] Discharge penis or vagina

Musculoskeletal

[ ] Muscle or joint pain

Skin

[ ] Rashes

[ ] Unusual moles

Allergy

[ ] Hay fever/itchy eyes

Neurological

[ ] Headaches

[ ] Clumsiness

[ ] Weakness

Cardiovascular

[ ] Tires easily with exertion

[ ] Fainting

[ ] Shortness of breath

Psychiatric/Emotional

[ ] Speech problems

[ ] Anxiety/stress

[ ] Sleep issues

[ ] Depression

[ ] Nail biting/thumb sucking

[ ] Bad temper/breath holding

(Office Use Only)

Date Seen: ______________________________

Parents Name: _________________________

Referring Physician Name: ____

Phone: ________________________________

Fax:

Vitals

(Entered into Epic)

WEIGHT: ____________

HEIGHT: ____________

BP: ____________

PULSE: ____________

TEMPERATURE: ____________