Pediatric Health History

Name: ______________________ DOB: __________ Sex: M F

Person completing form & relationship: ______________________

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

Past Medical History

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

Birth weight: _____ lbs. _____ oz. Length: _____ in. ❑ Full term or ❑ Premature, _____ wks.

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

____

Past Surgical and Hospitalization History

- ❑ Appendectomy
- ❑ Ear tubes
- ❑ Fracture, __________
- ❑ Hernia, R or L, type __________
- ❑ Psychiatric treatment, inpt or outpt
- ❑ Tonsillectomy
- Other: __________

Females Only: Age at first period: _______ yrs. old Birth control method __________

Number of: Pregnancies _______ Deliveries _______ Miscarriages _______ Abortions _______

Date of last: Period __________ Pap smear __________

Drug allergies: ❑ No Known Drug Allergies

Name of Drug	Reaction

(Turn page over for more questions)

Provider review: Signature ______________ Date ________
Provider review: Signature ______________ Date ________
Provider review: Signature ______________ Date ________
Provider review: Signature ______________ Date ________

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

Medication	Strength/Dose	Frequency

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.

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

Did newborn receive a hepatitis B shot in the hospital? ❑ Yes ❑ No, Hospital ______________

Social History:

Parents: ❑ Married ❑ Divorced, if divorced, who does child live with: ______________

Grade in school ________ . How is child doing? ❑ Good ❑ Fair ❑ Poor ❑ Dropped out

Tobacco: ❑ Cigarettes ❑ Smokeless How much/day ________ ; how long ________ . ❑ Quit, when ________

Alcohol use: Number of drinks or bottles of beer per week ______________

Caffeine: Number of cups of coffee _____ /day, glasses tea _____ /day, sodas _____ /day

Sexually active: ❑ Yes ❑ No New partner in the last year? ❑ Yes ❑ No

Victim of abuse: ❑ physical ❑ sexual ❑ mental Who is the abuser? ______________

Infant car seat, toddler seat or seat belt restraint used regularly: ❑ Yes ❑ No

Firearms (guns or rifles) in home: ❑ Yes ❑ No Under lock and key: ❑ Yes ❑ No

Exposure to hazardous materials: ______________

Travel to foreign countries: ______________

Special diet or vegetarian: ______________

Death in family in the last year? ❑ Yes ❑ No Relationship: ______________

Cigarette or cigar smokers in the home? ❑ Yes ❑ No

Members of household: ______________

Family History:

	Living		Deceased	
	Age	Health status or illness	Age	Cause of death & illnesses
Father				
Mother				
Father's father				
Father's mother				
Mother's father				
Mother's mother				
Brothers				
Sisters				

Parent or Guardian Signature ______________________ Date ________