**Pediatric Health History Form**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD’S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICINES/VITAMINS**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PREGNANCY & BIRTH**Where was your child born (Hospital/City)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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: \_\_\_\_\_\_\_\_\_\_\_ Birth length: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please indicate any medical problems during the baby’s newborn period:
None ❑ If premature, How early? \_\_\_\_\_\_\_\_ Other problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NUTRITION & FEEDING**Was/is your child breastfed? Yes ❑ No ❑ If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If your child is breastfed, are they on Vitamin D Supplement? Yes ❑ No ❑
Has your child had any feeding/dietary problems? Yes ❑ No ❑ If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Milk intake now: Type: Cow’s Milk ❑ (Nonfat 1% fat 2% fat Whole milk) Soy Milk ❑ Rice Milk ❑ Other\_\_\_\_\_\_\_\_Average ounces per day (Note 8 ounces = 1 cup) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SLEEP**Hours per night\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Naps (number & length)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any sleep problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DEVELOPMENT**At what age did your child: Sit Alone\_\_\_\_\_\_\_\_ Walk Alone\_\_\_\_\_\_\_ Say Words\_\_\_\_\_\_\_ Toilet Train (daytime)\_\_\_\_\_\_\_Girls only: Age at first menstrual period\_\_\_\_\_\_\_Any concerns about your child’s behavior or development? Yes ❑ No ❑  **DENTAL HISTORY**Has your child been seen by a dentist? Yes ❑ No ❑ Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If so, how often? \_\_\_\_\_\_\_\_\_\_\_ Date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Water Source: City ❑ Well ❑ Other\_\_\_\_\_\_\_
**SCHOOL HISTORY**Name of School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any concerns about school performance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any concerns about relationship with: *Teachers* Yes ❑ No ❑ *Student*  Yes ❑ No ❑

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**SAFETY**
When your child is in the car, does he/she use: An infant seat ❑ Booster Seat ❑ Seatbelt ❑
Do you have smoke detectors in your home? Yes ❑ No ❑
Does your child wear a helmet for a Bike/Scooter or ATV? Yes ❑ No ❑
Do any members in the household smoke or use tobacco? Yes ❑ No ❑
Are there any guns in the home? Yes ❑ No ❑
Is there any violence in the home? Yes ❑ No ❑
**IMMUNIZATIONS**Has your child had immunizations? Yes ❑ No ❑ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Has your child had? Chickenpox ❑ Measles ❑ Mumps ❑ Rubella ❑ Meningitis ❑ Tuberculosis (TB) **SOCIAL HISTORY**
Who lives at home?
Name Age Relationship Name Age Relationship
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your child’s parents: Married ❑ Unmarried ❑ Separated ❑ Divorced ❑
Child care: Parents ❑ Daycare ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Concerns about your child: None ❑ Alcohol Use ❑ Drug Use ❑ Tobacco ❑ Sexual Activity ❑ Aggressive Behavior ❑
Are there any pets in the home? Yes ❑ No ❑ I so what pet? Dog(s) ❑ Cats(s) ❑ Other ❑
TV-hours per day \_\_\_\_\_\_\_\_\_ Computer hours per day \_\_\_\_\_\_\_\_\_\_\_\_\_ Video games hours per day \_\_\_\_\_\_\_\_\_\_ **PAST MEDICAL HISTORY**Please describe any major medical problems and their dates. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Physicians or Specialists your Child sees (Names and specialty) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospitalizations/operations (with dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Broken bones or severe sprains:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAMILY HISTORY**
Please check below if any immediate (parent, sibling, or grandparent) family members have any of the listed conditions:

Alcoholism ❑
Cancer ❑ Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Depression/Suicide ❑
Diabetes ❑
Heart Attack ❑
High Blood Pressure ❑
High Cholesterol ❑
Stroke ❑
Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Constitutional**

Fever/chills/excessive sweating
Unexplained weight loss/gain

**Eyes**

Squinting/crossed eyes

**Ears/Nose/Throat**

Unusually load voice/hard of hearing
Mouth breathing/snoring
Bad Breath
Frequent runny nose
Problems with teeth/gums

**Cardiovascular**

Tires easily with exercise
Shortness of breath
Fainting

**Respiratory**

Cough/Wheeze
Chest Pain

**Gastrointestinal**

Nausea/vomiting/diarrhea
Constipation
Blood in Bowel Movement

**Genitourinary**

Bedwetting
Pain with urination
Discharge: penis or vagina

**Musculoskeletal**

Muscle/joint pain

**Skin**

Rashes
Unusual moles

**Neurological**

Headaches
Weakness
Clumsiness

**Psychiatric/Emotional**

Speech problems
Anxiety/stress
Problem with sleep/nightmares
Depression
Nail biting/thumb sucking
Bad temper/jealousy

**Blood/Lymph**

Unexplained lumps
Easy bruising/bleeding

**Allergy**

Hay Fever/itchy eyes