

## Pediatric Health History Form

Child's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Child's Previous Doctor: \_\_\_\_\_

Allergies/ Reactions to Medications or Vaccines: \_\_\_\_\_

Current Medications/ Vitamins: \_\_\_\_\_

Current Problems/ Concerns: \_\_\_\_\_

**Past Medical History:** (Please Check All That Apply)

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Asthma/Hay Fever/Eczema | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> RSV                |
| <input type="checkbox"/> Broken Bones            | <input type="checkbox"/> Croup       | <input type="checkbox"/> Attention Problems |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Other _____        |

(Please explain any "Yes" answers) \_\_\_\_\_

Hospitalizations/Surgeries (with dates): \_\_\_\_\_

**Immunizations/Exposures/Habits:** (Please bring a copy of your child's immunization record to all well child appointments)

Are your child's immunizations up to date?  Yes  No

Do any household members smoke?  Yes  No

Any concerns about lead exposure (old home/ plumbing/ peeling paint)?  No  Yes

TV, computers, video games: Hours per day \_\_\_\_\_

Physical activity: Hours per day \_\_\_\_\_

**Pregnancy & Birth:**

Any problems with the pregnancy?  No  Yes (Please explain) \_\_\_\_\_

Delivered by:  Vaginal Birth  Cesarean Birth

**Family History:** Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions

- |                             |                                  |
|-----------------------------|----------------------------------|
| Alcoholism _____            | High cholesterol _____           |
| Cancer (specify type) _____ | High blood pressure _____        |
| Heart disease/stroke _____  | Kidney disease _____             |
| Depression/anxiety _____    | Bleeding/clotting disorder _____ |
| Genetic Disorders _____     | Asthma/COPD _____                |
| Diabetes _____              | Other _____                      |

**Social History:**

Who does child live with?

Mom  Dad  Siblings (how many) \_\_\_\_\_  Grandma  Grandpa  Other \_\_\_\_\_

The Child's parents are:  Married  Unmarried, but living together  Separated  Divorced

Does your Child attend preschool/ school?  No  Yes Any concerns at school?  No  Yes, explain \_\_\_\_\_

**Review of Systems:** (Please check any current problems your child is experiencing)

Allergy

- Hay fever/itchy eyes  
 Unexplained weight loss/gain

General

- Fevers/chills/excessive sweating  
 Unexplained weight loss/gain

Eyes

- Squinting  
 Crossed eyes

Ears/Nose/Throat

- Unusual loud voice/hard of hearing  
 Mouth breathing/snoring  
 Frequent runny nose  
 Bad breath  
 Problems with teeth/gums

Respiratory

- Coughing/wheezing  
 Chest pain

Cardiovascular

- Tires easily with exertion  
 Shortness of breath  
 Fainting

Gastrointestinal

- Nausea  
 Constipation  
 Blood in bowel movement

Genitourinary

- Bedwetting  
 Pain with urination  
 Discharge: penis/vagina

Neurological

- Headaches  
 Weakness

Musculoskeletal

- Muscle/joint pain

Blood/Lymph

- Unexplained lumps  
 Easy bruising/bleeding

Psychiatric

- Speech problems  
 Depression  
 Sleep issues

Skin

- Rashes  
 Unusual moles