



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)

- Asthma/Hay Fever/Eczema Chicken Pox RSV
- Broken Bones Croup Attention Problems
- Frequent Ear Infections Pneumonia 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