PEDIATRIC HEALTH PARTNERS

Pediatric Health History Form

PATIENT LABEL

NAME: _____

DATE OF BIRTH: _____

AGE: _____

Your relationship to child: _____

Child's previous doctor/primary care provider: _____

Present health concerns:

Medicines/Vitamins:

Herbs/Home Remedies:

Allergies/Reactions to medicines or vaccinations:

PREGNANCY & BIRTH

Where was your child born? _____

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: _____

APGAR score 1 min. _____ 5 min. _____

Please indicate any medical problems during the baby's newborn period ☐ None (If premature, how early?)

_____

Other problems: _____

NUTRITION & FEEDING

Was your child breastfed? ☐ No ☐ Yes

If so, how long?

Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, specify:

_____

Milk intake now: Type ☐ Cow's milk (☐ Nonfat ☐ 1% fat ☐ 2% fat ☐ Whole) ☐ Soy milk ☐ Rice milk

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 _____

DENTAL HISTORY

Has child been seen by a dentist? ☐ No ☐ Yes

If so, how often? _____

Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:

☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

EXPOSURE/HABITS

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

Do any household members smoke? ☐ No ☐ Yes

TV – hours per day _____

Computers – hours per day _____

Video games – hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

_____

_____

_____

Hospitalization/operations (with dates):

Broken bones or severe sprains:

FAMILY HISTORY

Please indicate any deaths of your immediate family members:

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

Depression/suicide

Bleeding or clotting disorder

Genetic disorders

Asthma/COPD

Diabetes

Other:

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

If divorced or separated, when?

Mother's Occupation

Mother's Employer

Father's Occupation

Father's Employer

Child care situation ☐ Parents ☐ Others (specify who and how often)

Concerns about your child: ☐ Alcohol use ☐ Tobacco ☐ Sexual activity ☐ Aggressive behavior

Is violence at home a concern? ☐ No ☐ Yes

Are there guns in the home? ☐ No ☐ Yes

SCHOOL HISTORY

Did/does your child attend school or preschool?

☐ No ☐ Yes

Current grade

Name of school

Any concerns about school performance?

Any concerns about relationship with:

Teachers ☐ No ☐ Yes

Peers ☐ No ☐ Yes

If more than 4 years old: does your child have a best friend? ☐ No ☐ Yes

Sports/exercise: Type

How often?

How long (minutes)?

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

Cardiovascular
- ___ Tires easily with exertion
- ___ 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

Allergy
- ___ Hay fever/itchy eyes

Neurological
- ___ Headaches
- ___ Weakness
- ___ Clumsiness

Psychiatric/Emotional
- ___ Speech problems
- ___ Anxiety/stress
- ___ Sleep issues
- ___ Depression
- ___ Nail biting/thumb sucking
- ___ Bad temper/breath holding/ jealousy

Blood/Lymph
- ___ Unexplained lumps
- ___ Easy bruising/bleeding