# PEDIATRIC HEALTH HISTORY

**DATE** _____ **MEDICAL RECORD #** _____

Welcome to our Clinic! Your health is important to us. Please fill out this form as completely as you can. If you are unsure of how to answer a certain item, just circle it and we will be happy to discuss it with you. All information will be treated confidentially.

Patient Name _____ ☐Male ☐Female
First Middle Last

Date of Birth ___/____/_____ Where was your child born? _____

Previous Doctor:_____ Child's School/Daycare _____ Grade_____

**ALLERGIES** ☐ **None**

| Substance | Reaction |
|---|---|
| | |
| | |
| | |
| | |

**MEDICATIONS** ☐ **None**
**Please list all medications, over-the-counter & vitamins/supplements:**

| Medication Name | Dose | How Often? |
|---|---|---|
| | | |
| | | |
| | | |
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## FAMILY HISTORY

Please mark any condition that any of the patient's **parents, grandparents, brothers or sisters** have had:

| Condition | Who had it | Condition | Who had it |
|---|---|---|---|
| ☐ Addiction to alcohol or drugs | | ☐ Heart condition or murmur | |
| ☐ ADD/ADHD | | ☐ High blood pressure | |
| ☐ Allergies to pollen, cats, etc | | ☐ High cholesterol | |
| ☐ Anemia | | ☐ Infant death or SIDS | |
| ☐ Asthma | | ☐ Kidney disease/ Dialysis | |
| ☐ Birth defects | | ☐ Learning problems | |
| ☐ Cancer/ Leukemia | | ☐ Mentaldisease/disorder | |
| ☐ Depression | | ☐ Seizures/convulsions | |
| ☐ Diabetes | | ☐ Sickle cell | |
| ☐ Eye disorders/blindness | | ☐ Skin disease/ eczema | |
| ☐ Ear disorders/hearing loss | | ☐ Thyroid disease | |
| ☐ Headaches or Migraines | | ☐ Tuberculosis | |
| ☐ Heart attack under age 55 | | ☐ Weight problems | |

Please list any other medical conditions present in the family:

**PATIENT NAME** _____ **MEDICAL RECORD #** _____

# MEDICAL HISTORY

Please mark ☒ only if your child has had problems with:

| | | | | | |
|---|---|---|---|---|---|
| ☐ | ADD/ ADHD | ☐ | Diabetes | ☐ | Pain, weakness, swelling in: |
| ☐ | AIDS/ HIV | ☐ | Diaper rash, persistent | ☐ | Arms |
| ☐ | Allergies or Hay fever | ☐ | Diarrhea, persistent | ☐ | Back |
| ☐ | Anemia | ☐ | Discharge from penis | ☐ | Knees |
| ☐ | Anorexia | ☐ | Discharge from vagina | ☐ | Legs |
| ☐ | Appetite poor | ☐ | Drug use | ☐ | Rashes/Hives, recurrent |
| ☐ | Asthma | ☐ | Ear Infections, more than 3 | ☐ | Reflux, acid |
| ☐ | Bed-wetting, after age 4 | ☐ | Eye problems | ☐ | School problems |
| ☐ | Behavior problems | ☐ | Fainting, dizziness | ☐ | Scoliosis, curved back |
| ☐ | Birth defects | ☐ | Fainting with exercise | ☐ | Seizures/ convulsions |
| ☐ | Bladder infections | ☐ | Genetic conditions | ☐ | Sexually transmitted infection |
| ☐ | Blood in urine | ☐ | Headaches/ Migraines | ☐ | Sickle cell |
| ☐ | Blood in stools | ☐ | Hearing problems | ☐ | Sinus problems, recurrent |
| ☐ | Breathing problems | ☐ | Heart murmur | ☐ | Skin Problems/ Eczema |
| ☐ | Broken bones or sprains | ☐ | Heart problems | ☐ | Sleep Apnea |
| ☐ | Bronchitis/Bronchiolitis | ☐ | Hepatitis | ☐ | Sleep Problems |
| ☐ | Bruises easily | ☐ | Immune Problems | ☐ | Snoring, severe |
| ☐ | Bulimia | ☐ | Itching | ☐ | Speech problems: |
| ☐ | Cancer/leukemia | ☐ | Kidney infections | ☐ | Stomach aches, recurrent |
| ☐ | Chest pain | ☐ | Kidney problems | ☐ | Thyroid problems |
| ☐ | Chicken Pox, age: | ☐ | Menstrual Problems | ☐ | Tiredness |
| ☐ | Clumsiness | ☐ | Mental Illness | ☐ | Tonsil infections, recurrent |
| ☐ | Congestion, persistent | ☐ | Moles changing | ☐ | Tuberculosis, PPD+ |
| ☐ | Constipation, recurrent | ☐ | Mouth-breathing, persistent | ☐ | Underweight |
| ☐ | Coughing most nights | ☐ | Nosebleeds, more than 3 | ☐ | Vision problems |
| ☐ | Coughing with exercise | ☐ | Overweight | ☐ | Vomiting, recurrent |
| ☐ | Depression | ☐ | Pneumonia, more than once | ☐ | Wheezing |

**Please write any specific concerns you have about your child:**

**Do you have a copy of your child's immunization records?** Yes No

**Was your child premature by more than 2 weeks? Yes No** **Birth weight:**

**Were there any complications before, during, or just after birth?**

**Smoking:** Mom Dad StepMom StepDad Brother(s) Sister(s) Grandparent(s) Other NONE

**Pets:** None Dog Cat Fish Reptiles Other:

**Does your child use**: Rear-facing car seat Front-facing car seat Booster Seatbelt None

**PATIENT NAME** _____ **MEDICAL RECORD #** _____

**Has your child ever been hospitalized overnight? YES NO**

| DATE | AGE | REASON | WHERE? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Has your child ever had any surgeries or special procedures? YES NO**

| DATE | AGE | SURGERY/ PROCEDURE | WHERE? |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

**Has your child ever been to the Eye Doctor? Yes No Last visit date:** _____
**Has your child ever been to the Dentist? Yes No Last visit date:** _____

**Girls Only: Has your daughter started her periods yet? Yes No**
**At what age did she start her periods?** _____
**First day of last period:** _____

## HOUSEHOLD

Please list everyone who lives at home with your child:

| FULL NAME | | AGE | | RELATIONSHIP | |
|---|---|---|---|---|---|
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## EDUCATION AND SOCIAL HISTORY

How many hours per day does your child watch television, use a computer, or play video games? _____
How many hours per day does your child get exercise? _____
How is your child doing in school? _____

Do you suspect that your child is involved with: ☐ Tobacco ☐ Alcohol ☐ Drugs ☐ None
Has your child ever been in counseling? Yes No Where and why? _____

Have you noticed any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Angry behavior | ☐ NO | ☐ YES | Depression | ☐ NO | ☐ YES |
| Changes in appearance | ☐ NO | ☐ YES | Signs of drugs in the house | ☐ NO | ☐ YES |
| Changes in attitude | ☐ NO | ☐ YES | Skipping school | ☐ NO | ☐ YES |
| Changes in friendships | ☐ NO | ☐ YES | Withdrawal from friends or family | ☐ NO | ☐ YES |