Pediatric Health History Form- Initial Visit

Child's Name: ______________________ **Date of Birth:** __________ **Age:** ______

Parent Name: ______________________ **Relationship to Child:** __________________

Child's Past Medical History:

Pregnancy/Neonatal Period

Where was your child born? ______________________________

Is the child yours by: ☐ birth ☐ adoption ☐ stepchild ☐ other: ______________

Pregnancy complications: ______________________________

Delivery by: ☐ vaginal ☐ c-section

Reason for c-section: ______________________________

Complications: ______________________________

Was your child premature ☐ No ☐ Yes, born at ________ weeks

Complications: ______________________________

Apgars scores 1 minute: __________ **5 minutes:** ________

Birth weight: ______________ **Length:** ______________

Other problems in the newborn period: ______________________________

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ **Asthma or reactive airway disease:** ______________________________
- ☐ **Wheezing or bronchiolitis:** ______________________________
- ☐ **Seasonal allergies or eczema:** ______________________________
- ☐ **Food allergy:** ______________________________
- ☐ **Recurrent ear infections:** ______________________________
- ☐ **Pneumonia:** ______________________________
- ☐ **Urinary tract infections:** ______________________________
- ☐ **Genetic syndrome:** ______________________________

- ☐ Seizures: ______
- ☐ Anemia: ______
- ☐ Broken bones: ______
- ☐ Mental retardation or learning disability: ______
- ☐ Depression/anxiety: ______

Other chronic medical conditions: ______

Has your child ever been hospitalized ☐ No ☐ Yes (explain) ______

Previous surgeries and dates: ______

Please list any specialist your child is currently seeing and reason: ______

______

______

Medications:

ALLERGIES **to medicine/vaccines (list and describe reaction):** ______

______

Current medications and does: ______

______

______

Vitamins: ______

Herbal supplements: ______

Over-the-counter meds: ______

Development/Nutrition's

At what age did your child:

Walk alone:______ Sit alone: ______ Toilet Train: ______

Say Words: ______ 1st periods (females):______

Was your child breastfed ☐ No ☐ Yes, how long? ______

Has your child had any unusual feeding/dietary problems? (explain)______

______

Current milk intake: Type: ______ Amount: ______oz

Social History

Who lives in the household with the child? ☐Mom ☐ Dad ☐ Siblings (#_____) ☐ Grandparents ☐ Other ______

Child's parents are: ☐ Married ☐ unmarried ☐ divorced ☐ other

Childcare: ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) ______

Do any household members smoke? ☐ Yes ☐ No

How many hours per day dose you child spend? ☐ Watching ☐ TV____ ☐ Computer____ ☐ Video games ______

Child's school name: ______ Grade: ______

Any concerns about school performance? ☐ No ☐ Yes (explain) ______

______

Any concerns about peer or teacher relationships? ☐ No ☐ Yes (explain) ______

______

Sports/exercises: Type ______

How often? ______ How long? ______min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depressions/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
________________	☐	☐	☐	☐

Please explain all positive. ____

____

____

Review of Systems (√ all that apply)

→ ***Constitutional***

- ☐ Fever, chills
- ☐ Fatigue
- ☐ Unexplained weight loss/gain
- ☐ Excessive Thirst

→ ***Ear, Nose, and Throat***

- ☐ Load voice, hearing problem
- ☐ Mouth-breathing, snoring
- ☐ Ear pain
- ☐ Frequent runny

→ ***Respiratory***

- ☐ Cough, short of breath
- ☐ Chest tightness, wheeze

→ ***Musculoskeletal***

- ☐ Muscle pain, weakness
- ☐ Joint pain, swelling

- ☐ Bone pain

→ *Gastrointestinal*
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Chest pain, palpations

→ *Cardiovascular*
- ☐ Chest pain, palpations
- ☐ Tired easily exertion
- ☐ Fainting

→ *Genitourinary*
- ☐ Frequent or painful urination
- ☐ Bedwetting, frequent accidents
- ☐ Vaginal or penis discharge

→ *Neurologic*
- ☐ Headaches
- ☐ Seizures
- ☐ Clumsiness
- ☐ Milestone delay

→ *Psychiatric/emotional*
- ☐ Anxiety/stress
- ☐ Depression
- ☐ Sleep problems
- ☐ Anger concern
- ☐ Concern with attention, impulsivity

Reviewed by: ______________________________ Date: ______________