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Please print, complete and bring to your appointment

Pediatric Health History Form

Date: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Present Health Concerns: _____

Medicines/Vitamins: _____

Herbs/Home Remedies: _____

Allergies/Reactions to Medications or Vaccinations: _____

Past Medical History: Please describe any major medical problems (Asthma, Seizures, Heart Problems, Diabetes, etc)

Hospitalizations/Operations: _____

Broken bones or severe sprain: _____

Dental History: Has child been seen by a dentist? No Yes If so, how often? _____ Date of last visit _____

Immunizations: Please bring your child's immunization records with you

Immunizations up to date? Yes No

Infectious Diseases:

Has your child had : Chicken Pox Measles Mumps Rubella Meningitis Tuberculosis
 Pertussis/Whooping Cough Other _____

Family/Social History

Who lives at home?

Name

Age

Relationship

Do both natural parents live at home?: _____

Exposures/Habits:

Does anyone in the home smoke? Yes No

Are there any pets in the home? Yes No

Any concerns about lead exposure? Yes No

Pregnancy and Birth

Where was your child born: _____

Is the child yours by: Birth Adoption Stepchild Other: _____

Please indicate any medical problems during the pregnancy: _____

Delivery by: Vaginal birth Cesarean If Cesarean, why? _____

Birth Weight: _____ Birth length: _____ APGAR score 1 min _____ 5 min _____

If premature, how early? _____

Please indicate any medical problems during the baby's newborn period _____

Review of Systems

Please "X" any current problems your child has on the list below

Constitutional

- _____ Fever/chills/excessive sweating
- _____ Unexplained weight loss/gain

Eyes

- _____ Squinting/"crossed" eyes
- _____ Asymmetric gaze

Ear/Nose/Throat

- _____ Unusually loud voice
- _____ Hard of hearing
- _____ Mouth breathing/snoring
- _____ Bad breath
- _____ Frequently 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 stool

Genitourinary

- _____ Bedwetting
- _____ Pain with urination
- _____ Discharge (penis/vagina)

Musculoskeletal

- _____ Muscle/joint pain

Skin

- _____ Rashes
- _____ Unusual moles

Allergy

- _____ Hay fever/itchy eyes

Neurological

- _____ Headaches
- _____ Weakness
- _____ Clumsiness
- _____ Seizures

Psychiatric/Emotional

- _____ Anxiety/Stress
- _____ Depression
- _____ Speech problems
- _____ Sleep problems
- _____ Nail biting/thumb sucking
- _____ Bad Temper/breath

Lymph/Blood

- _____ Unexplained lumps
- _____ Easy bruising/bleeding