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## 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 _____

_____

## Family History

Please indicate with an "**X**", family members who have had any of the following conditions:

| Medical Condition | Mom | Dad | Sister | Brother | Mom's Mom | Mom's Dad | Mom's Sister | Mom's Brother | Dad's Mom | Dad's Dad | Dad's Sister | Dad's Brother |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dermatology | | | | | | | | | | | | |
| Eczema | | | | | | | | | | | | |
| Hearing Disorder | | | | | | | | | | | | |
| Environmental Allergies | | | | | | | | | | | | |
| Food Allergies | | | | | | | | | | | | |
| Respiratory | | | | | | | | | | | | |
| Asthma | | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | | |
| Cardiovascular | | | | | | | | | | | | |
| Hypertension | | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | |
| Congenital Heart Defect | | | | | | | | | | | | |
| Gastrointestinal | | | | | | | | | | | | |
| Gallstones | | | | | | | | | | | | |
| Irritable Bowel | | | | | | | | | | | | |
| Ulcerative Colitis | | | | | | | | | | | | |
| Crohn's | | | | | | | | | | | | |
| Pyloric Stenosis | | | | | | | | | | | | |
| GERD | | | | | | | | | | | | |
| Renal Disorders | | | | | | | | | | | | |
| Polycystic Syndrome | | | | | | | | | | | | |
| Urology | | | | | | | | | | | | |
| VU Reflux | | | | | | | | | | | | |
| Gynecology | | | | | | | | | | | | |
| Rheumatology | | | | | | | | | | | | |
| Rheumatoid Arthritis | | | | | | | | | | | | |
| Lupus | | | | | | | | | | | | |
| Endocrinology | | | | | | | | | | | | |
| Diabetes, Type I | | | | | | | | | | | | |
| Diabetes, Type II | | | | | | | | | | | | |
| Thyroid | | | | | | | | | | | | |
| Orthopedic | | | | | | | | | | | | |
| Congenital Hip Dysplasia | | | | | | | | | | | | |
| Hematology | | | | | | | | | | | | |
| Anemia | | | | | | | | | | | | |
| Bleeding Disorder | | | | | | | | | | | | |
| Cancer | | | | | | | | | | | | |
| Immunology | | | | | | | | | | | | |
| Neurology | | | | | | | | | | | | |
| Headaches | | | | | | | | | | | | |
| Epilepsy | | | | | | | | | | | | |
| Developmental Delay | | | | | | | | | | | | |
| Psychiatric | | | | | | | | | | | | |
| ADD | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | |
| Genetic | | | | | | | | | | | | |
| Congenital anomaly | | | | | | | | | | | | |
| Death before age 56 for reason not listed above | | | | | | | | | | | | |
| Other | | | | | | | | | | | | |
| Other | | | | | | | | | | | | |
| Other | | | | | | | | | | | | |
| Other | | | | | | | | | | | | |

**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