Name: ______________________

Date of Birth: ______________________

Today's Date: ______________________

Pediatric Health History Form

Your relationship to child: ______________________

Child's Previous Doctor/Primary Care Provider:

____

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 problems during pregnancy
☐ None ☐ Specify: ______________________

Delivery by ☐ Vaginal ☐ Caesarean

If caesarean, why? ______________________

Mother's age at delivery? ______________________

Gestational Age: ______________________

Birth weight: ____________ Birth length: ____________

Apgar score 1 min. ________ 5 min. ________

Please indicate any medical problems during the baby's newborn period ☐ None ______________________

____

____

Nutrition & Feeding

Was your child breastfed? ☐ Yes ☐ No

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) ______________________

Dental History

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

Is 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 pain) ☐ No ☐ Yes

Water source? ☐ City ☐ Well ☐ Bottled

Do any household members smoke? ☐ No ☐ Yes

TV – hour per day ______________________

Computers – hours per day ____________

Video Games – hours per day ____________

School History

Did/does your child attend school or preschool?
☐ No ☐ Yes

Current Grade ______________________

Name of School ______________________

Any concerns about school performance? ☐ No ☐ Yes ______________________

Any concerns about relationship with:
Teachers ☐ No ☐ Yes
Peers ☐ No ☐ Yes

____

Past Medical History
(Please describe any major medical problems and their dates.) ☐ None

____

____

____

☐ Asthma ☐ Seasonal Allergies ☐ ADHD ☐Eczema
☐ Recurrent ear infections ☐ Constipation
☐ Urinary tract/bladder/kidney infections
Hospitalizations with reasons and dates ☐ None

____

____

Surgeries with type and dates ☐ None

____

____

Broken Bones or severe sprains with dates ☐ None

____

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? ____________
If split custody, please describe the arrangement.

____

____

Mother's Occupation ____________
Mother's Employer ____________
Father's Occupation ____________
Father's Employer ____________

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

____

Safety
Are there guns in the home? ☐ No ☐ Yes
Is violence at home a concern? ☐ No ☐ Yes
When your child is in the car does he/she use:
☐ Infant seat ☐ Booster seat
☐ Seat belt only ☐ Nothing
Do you have smoke detectors at home? ☐ Yes ☐ No
Does the child wear a helmet for bike/ scooter or ATV?
☐ Yes ☐ No

Family History
Please check the disease if anyone in your child's family (parents, grandparents, brother/sister, aunts, uncles, or cousins) have the disease and write your child's relationship to that person.

☐ Alcohol / Drug Abuse ____________

☐ ADHD ____________

☐ Anemia / Sickle Cell Anemia ____________

☐ Allergies / Hay Fever ____________

☐ Asthma ____________

☐ Bleeding Problems ____________

☐ Cancer ____________

☐ High Cholesterol ____________

☐ Deafness ____________

☐ Adult Onset Diabetes ____________

☐ Childhood Onset Diabetes ____________

☐ Genetic Disorders ____________

☐ Heart Attack (<65 yo) ____________

☐ Congenital Heart Disease (heart problems or different shaped heart from birth) ____________

☐ High Blood Pressure ____________

☐ Kidney Disease ____________

☐ Mental Illness, Suicide, "trouble with nerves"

____

☐ Seizures ____________

☐ Stroke ____________

☐ Sudden Unexplained Death ____________

☐ Thyroid Disease ____________

☐ Other ____________

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