Pediatric Health History

CHILD'S NAME: _____DATE OF BIRTH: _____ AGE: _____

DOCTOR/PCP seen today: _____

CHILD'S PREVIOUS DOCTOR/PCP: _____

BIRTH AND PREGNANCY

What city was your child born in? _____ Name of hospital:_____

Is this your child by: ‰ Birth Adoption ‰ Step-child ‰ Other: _____

Birth weight: _____ Was your baby premature? Y / N

Were there any significant medical problems during your pregnancy? Y / N

Were there any significant complications during labor or the baby's newborn period? Y / N

If yes, to any of the above questions, please explain: _____

_____

GROWTH AND DEVELOPMENT

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)? Y / N

If yes, please explain: _____

Girls only: Age at first period: _____

PAST MEDICAL HISTORY

HAS YOUR CHILD:

Had any serious medical illness?	Y / N	Had broken bones/frequent or severe sprains?	Y / N
Had a history of asthma or wheezing?	Y / N	Had any mental or behavioral problems?	Y / N
Ever used an inhaler or nebulizer?	Y / N	Had a positive tuberculosis skin test?	Y / N
Had surgery?	Y / N	Been hospitalized overnight?	Y / N

If yes, to any of the above, please explain: _____

IMMUNIZATIONS *Please bring your child's immunization records to your appointment*

Have you ever refused vaccines for your child? Y / N

If yes, why? _____

MEDICATIONS AND ALLERGIES Please list current medications, vitamins, and supplements, even those used intermittently: _____

Please list allergies or reactions to medications, vaccines or foods

Allergy & Reaction:

_____

_____

_____

Child's Name_____

FAMILY HISTORY: Please indicate with a [X] family members who have had any of the following conditions:
My child is adopted ____

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism/ Substance abuse												
Anemia												
Asthma												
Autism												
Autoimmune Disorder												
Birth Defect/Congenital Anomaly												
Bleeding Problem												
Cancer, Breast												
Cancer: Please Specify Type _____												
Cancer: Please Specify Type _____												
Diabetes												
Eczema (Atopic Dermatitis)												
Food Allergy												
Hay Fever (Allergic Rhinitis)												
Hearing Disorder												
Heart Attack/Coronary Artery Disease												
High Blood Pressure (Hypertension)												
High Cholesterol												
Psychiatric/Mental Illness												
Stroke												
Tobacco Use												
Death before age 56 or reasons not listed above												
Other												
Other:												

SOCIAL HISTORY: Please list patient's family and household members:

Name	Age	Relationship	Occupation/Employer	Cell Phone Number

Are your child's parents: Married Unmarried Separated Divorced (If divorced or separated, when?) _____

Child-care situation: Parents Others (specify who and hours per day) _____

_____

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern?	Yes	No	Are there pets in the home?	Yes	No
Are there guns in the home?	Yes	No	Do any family members smoke?	Yes	No

Child's Name_____

Parent's Name_____

Parent's signature_____

Physician's signature and date_____