

## Pediatric Health History Form

**Child's Name:** \_\_\_\_\_ **Child's Birthdate:** \_\_\_\_\_ **Child's Previous Doctor:** \_\_\_\_\_

**Current Problems/Concerns:** \_\_\_\_\_

**Allergies/Reactions to Medicines or Vaccines:** \_\_\_\_\_

**Current Medicines:** \_\_\_\_\_

**Pregnancy & Birth:**

Any problems with the pregnancy?  No.  Yes (please specify:)

Delivered by:  vaginal birth  caesarian (please explain why:)

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_

**Immunizations/exposures:**

Are your child's immunizations up to date?  No  Yes **Please bring your child's shot record.**

Does your insurance cover immunizations?  No  Yes **(If "no," your child may be eligible for free immunizations.)**

Do any household members smoke?  No  Yes Any concerns about lead exposure? (old home/plumbing/peeling paint)  No  Yes

**Past Medical History:** Does your child have any of the following conditions? Please check all that apply:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Asthma / hay fever / eczema | <input type="checkbox"/> Broken bones         | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Chicken pox              |
| <input type="checkbox"/> Attention problems          | <input type="checkbox"/> Problems going potty | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Obesity                  |
| <input type="checkbox"/> Croup                       | <input type="checkbox"/> Anemia               | <input type="checkbox"/> RSV                     | <input type="checkbox"/> Urinary tract infections |

**Past Surgical History:** Has your child had any operations such as circumcision, hernia repair, or tonsillectomy?  No  Yes (please explain):

**Family History:** Please check any family history of the following and indicate who has/had the condition (M = mother, F = father, B = brother, S = sister, G = grandparent, E = extended family):

	M	F	B	S	G	E		M	F	B	S	G	E
<input type="checkbox"/> Alcoholism/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bleeding / clotting problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart disease or stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Asthma / hay fever / eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Inherited/genetic diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							

**Social History:** Please list the names of all people who live with the child

Name	Age	Relationship	Name	Age	Relationship

The child's parents are:  married.  unmarried but living together.  separated.  divorced.

Mother's occupation: \_\_\_\_\_ Father's occupation: \_\_\_\_\_

Child care situation:  lives with parents  lives with others (please explain):

Is violence at home a concern?  No  Yes Are there guns at home?  No  Yes

**School History:**

Does your child attend preschool/school?  No  Yes Grade: \_\_\_\_\_ School: \_\_\_\_\_

Any concerns about school performance?  No  Yes (if yes, please explain:)