

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): _____