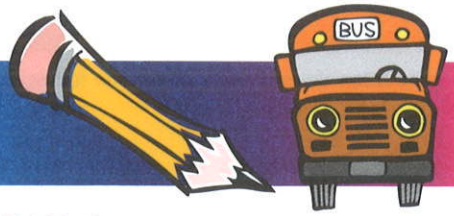
Keeping your child healthy is our #1 priority



PEDIATRIC HEALTH HISTORY

Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated confidentially.

Date _____ SS/HIC/Patient ID # _____

Child's Name _____ ☐ M ☐ F Date of Birth _____ Age _____

Mother's Name _____ Phone: Home (_____) _____ Work (_____) _____

Father's Name _____ Phone: Home (_____) _____ Work (_____) _____

Home Address _____

E-mail _____ Phone: Cell #1 (_____) _____ Cell #2 (_____) _____

Child's School _____ Grade _____

Previous Physician _____ City/State _____ Phone (_____) _____

ALLERGIES

Substance	Reaction

MEDICATIONS

Medication Name	Dosage

MEDICAL HISTORY

Please check ☑ if child has ever had any of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis/Bronchiolitis
- ☐ Bronchopulmonary Dysplasia (BPD)
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Immune Deficiency/HIV
- ☐ Measles (10-day)
- ☐ Measles, Rubella (3-day)
- ☐ Mumps
- ☐ Prematurity
- ☐ Rheumatic fever
- ☐ Pneumonia
- ☐ Sickle Cell Disease
- ☐ Whooping cough
- ☐ Other _____

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Mood swings
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweating
- ☐ Tiredness
- ☐ Weight loss/gain

CARDIOVASCULAR

- ☐ Breathing problems
- ☐ Chest pain
- ☐ Irregular heart beat

EYES

- ☐ Crossed or wandering eyes
- ☐ Eye irritation
- ☐ Headaches
- ☐ Vision problems

HEARING/SPEECH

- ☐ Difficulty hearing
- ☐ Earache
- ☐ Ear infections
- ☐ Hoarseness
- ☐ Speech problems _____

DENTAL

- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Sensitivity to hot/cold
- ☐ Thumb-sucking
- ☐ Last dental check-up Date _____
- ☐ Brush, how often? _____
- ☐ Floss, how often? _____

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloody or dark stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomachaches
- ☐ Vomiting
- ☐ Worms

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Diaper rash, persistent
- ☐ Discharge from vagina or penis
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Unusual urine odor

MUSCLE/JOINT/BONE

- ☐ Broken bones or sprains
- ☐ Coordination problems
- ☐ Posture problems
- ☐ Pain, weakness, swelling in:
  - ☐ Arms ☐ Hips
  - ☐ Back ☐ Legs
  - ☐ Feet ☐ Neck
  - ☐ Hands ☐ Shoulders

NOSE/THROAT/CHEST

- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Mouth-breathing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sore throats
- ☐ Strep throat
- ☐ Tonsil infections
- ☐ Wheezing

SKIN

- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

DIETARY ASSESSMENT

How often does your child eat the following:

	3 Times Daily	Daily	Weekly	Monthly
Beans, peas	☐	☐	☐	☐
Breads, cereals, grains	☐	☐	☐	☐
Candy	☐	☐	☐	☐
Dairy products	☐	☐	☐	☐
Eggs	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Meats	☐	☐	☐	☐
Poultry, fish	☐	☐	☐	☐
Sodas	☐	☐	☐	☐
Vegetables, green	☐	☐	☐	☐
Vegetables, yellow	☐	☐	☐	☐

What vitamin supplements does your child take? _____ How often? _____

Is there fluoride in your water? ☐ Yes ☐ No

HOSPITALIZATIONS

Reason	Date	Hospital, City, State

INJURIES

Serious Injuries/Illnesses	Date	Outcome

Has your child ever had a blood transfusion? ☐ Yes ☐ No

IMMUNIZATIONS

Please check ☑ whether or not your child has been given the following immunizations. If yes, please fill in the date(s) given.

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
☐	☐	_____	Hepatitis B	☐	☐	_____	Polio shots, series of 3	☐	☐	_____	Measles Vaccine
☐	☐	_____	DPT, series of 3 shots	☐	☐	_____	Polio booster shots	☐	☐	_____	Mumps Vaccine
☐	☐	_____	DPT booster shots	☐	☐	_____	Polio by mouth, series of 3	☐	☐	_____	Rubella Vaccine
☐	☐	_____	Hib (Influenza)	☐	☐	_____	PCV7 (Pneumococcal)	☐	☐	_____	Chicken Pox Vaccine

FAMILY HISTORY

Please give the following information about your child's immediate family:

	Age	General Health		Age	General Health	
Father	_____	_____	Sibling	_____	_____	☐ M ☐ F
Mother	_____	_____	Sibling	_____	_____	☐ M ☐ F
Have any of your children died? ☐ Yes ☐ No			Sibling	_____	_____	☐ M ☐ F

Please check ☑ conditions that any of the child's blood relatives (including parents and siblings) have had and the relationship to the child:

Condition	Relationship	Condition	Relationship
☐ Alcoholism	_____	☐ HIV/AIDS	_____
☐ Allergies	_____	☐ Kidney disease	_____
☐ Anemia	_____	☐ Lung disease	_____
☐ Arthritis	_____	☐ Mental disease/disorder	_____
☐ Asthma/emphysema	_____	☐ Mental retardation	_____
☐ Birth defects	_____	☐ Muscle disorders	_____
☐ Bone/joint disorders	_____	☐ Rheumatic fever	_____
☐ Cancer	_____	☐ Seizures/convulsions	_____
☐ Diabetes	_____	☐ Sickle cell anemia	_____
☐ Epilepsy	_____	☐ Skin disease	_____
☐ Eye or ear disorders/Hearing loss/Blindness	_____	☐ Stroke	_____
☐ Genetic defects	_____	☐ Thyroid disease	_____
☐ Heart disease	_____	☐ Tuberculosis	_____
☐ Hemophilia	_____	☐ Venereal disease	_____
☐ High blood pressure	_____	☐ Other	_____

PRE-NATAL AND INFANT HEALTH HISTORY

Place of birth _____ Obstetrician _____ Mother's age at birth _____

During the pregnancy which conditions did you have? Please ☑ all that apply:

- ☐ Alcohol use
- ☐ Anemia
- ☐ Diabetes
- ☐ Drug use, non-prescription drugs (Please list) _____
- ☐ Drug use, prescription drugs (Please list) _____
- ☐ Drug use, controlled drugs such as narcotics (Please list) _____
- ☐ Edema (Swelling)
- ☐ Exposure to chemical or radiation
- ☐ Fever
- ☐ German measles
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Protein in urine
- ☐ Tobacco use
- ☐ Urinary tract infection
- ☐ Venereal disease
- ☐ Other illnesses or infections _____

DELIVERY Please check ☑ all that apply:

☐ On time ☐ Premature ☐ Late ☐ Normal ☐ Induced ☐ Prolonged ☐ Breech ☐ C-Section

Please describe _____

INFANT HEALTH

Birthweight _____ Length _____

Discharge weight _____ Age when discharged _____

INFANT HEALTH PROBLEMS Please check ☑ and describe.

- ☐ Birth defects _____
- ☐ Breathing problems _____
- ☐ Infection _____
- ☐ Jaundice _____
- ☐ Transfusion _____
- ☐ Other _____

FEEDING

☐ Breast fed ☐ Formula fed

DEVELOPMENTAL Please note age at which your child:

Lifted head	_____	Wk.
Rolled over	_____	Mo.
Cooed/Laughed	_____	Mo.
Sat up	_____	Mo.
Stood up	_____	Mo.
Walked	_____	Mo.
Finger fed	_____	Mo.
Drank from cup	_____	Mo.
Spoon fed	_____	Mo.
First word	_____	Mo.
Toilet trained	_____	Mo.
Dressed self	_____	Mo.

EDUCATION AND SOCIAL HISTORY

Please explain any problems or concerns you have about your child in any of the following areas:

Appearance/Weight/Height _____

Behavior _____

Friends _____

Grades/learning ability _____

Sexuality _____

How many hours per day does your child watch television or play video games? _____ Get exercise? _____

Do you suspect that your child is involved with: ☐ Drugs ☐ Alcohol ☐ Tobacco ☐ None

Have you noticed any of the following warning signs of drug abuse:

Angry behavior	☐ No	☐ Yes	Depression	☐ No	☐ Yes
Changes in appearance	☐ No	☐ Yes	Signs of drugs in the house	☐ No	☐ Yes
Changes in attitude	☐ No	☐ Yes	Skipping school	☐ No	☐ Yes
Changes in friendships	☐ No	☐ Yes	Withdrawal from friends or family	☐ No	☐ Yes

CHILD SAFETY INVENTORY

Adequate number of working smoke alarms?	☐ Yes ☐ No	Safety plugs in unused wall sockets?	☐ Yes ☐ No
Does child use car seat/seat belt?	☐ Yes ☐ No	Safety gate for stairs?	☐ Yes ☐ No
Medicines, cleaning supplies, chemicals out of reach?	☐ Yes ☐ No	Know dangers of peeling paint, mice/rats in the home?	☐ Yes ☐ No
Syrup of Ipecac in the home?	☐ Yes ☐ No	Does child know how to swim?	☐ Yes ☐ No
Know poison control phone number?	☐ Yes ☐ No	Are guns in the home in locked storage?	☐ Yes ☐ No
Water heater set below 120°F?	☐ Yes ☐ No	Does child use bicycle helmet?	☐ Yes ☐ No

PARENT CONCERNS Reason for visit today and any other concerns or questions you have about your child.

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient

DR. COMMENTS

Physician Signature

Date

UPDATES (To be filled in at future appointments)

Has there been any change in child's health since last appointment? ☐ Yes ☐ No

Please describe

Parent/Guardian Signature | Date | Physician Signature | Date

Has there been any change in child's health since last appointment? ☐ Yes ☐ No

Please describe

Parent/Guardian Signature | Date | Physician Signature | Date

Has there been any change in child's health since last appointment? ☐ Yes ☐ No

Please describe

Parent/Guardian Signature | Date | Physician Signature | Date