

Pediatric Health History Form – Initial Visit

CHART #

Child's Name _____ Date of Birth _____ Age _____
 Your Name _____ Relationship to Child _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____
 Is the child yours by birth adoption stepchild other
 Pregnancy complications _____
 Delivery by vaginal c-section
 Reason for c-section _____
 Complications _____
 Was your child premature No Yes, born at _____ weeks
 Complications _____
 Apgar scores 1 minute _____ 5 minutes _____
 Birth weight _____ Length _____
 Other problems in the newborn period _____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)
 Asthma or reactive airway disease _____
 Wheezing or bronchiolitis _____
 Seasonal allergies or eczema _____
 Food allergy _____
 Recurrent ear infections _____
 Pneumonia _____
 Urinary tract infections _____
 Genetic syndrome _____
 Seizures _____
 Anemia _____
 Broken bone _____
 Mental retardation or learning disability _____
 Depression/anxiety _____
 Other chronic medical conditions _____

Has your child ever been hospitalized No Yes (explain)

Previous surgeries and dates _____

Please list any specialist your child is currently seeing and reason:

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

Current medications and dose: _____

Vitamins _____
 Herbal supplements _____
 Over-the-counter meds _____

Development/Nutrition

At what age did your child: Sit alone _____
 Walk alone _____ Say words _____
 Toilet train(day) _____ 1st period (females) _____
 Was your child breastfed No Yes, how long? _____
 Has your child had any unusual feeding/dietary problems? Explain.

 Current milk intake: Type _____ Amount _____ oz/d

Social History

Who lives in the household with the child? Mom Dad
 Siblings (# _____) Grandparents Other _____
 Child's parents are married unmarried divorced other
 Childcare parents relatives daycare babysitter/nanny
 Days per week in childcare (not with parents) _____
 Do any household members smoke Yes No
 How many hours per day does your child spend:
 Watching TV _____ Computer _____ Video games _____
 Child's school name _____ Grade _____
 Any concerns about school performance? No Yes, explain

 Any concerns about peer or teacher relationships? No Yes

 Sports/exercise: Type _____
 How often? _____ How long _____ min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<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"/>
Heart attack/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<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"/>
Stroke	<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"/>
Thyroid disease	<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"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain all positives. _____

Review of Systems (Check all that apply)

<p><u>Constitutional</u> <input type="checkbox"/> Fever, chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Unexplained weight loss/gain <input type="checkbox"/> Excessive thirst</p> <p><u>Ear, Nose, and Throat</u> <input type="checkbox"/> Loud voice, hearing problem <input type="checkbox"/> Mouth-breathing, snoring <input type="checkbox"/> Ear pain <input type="checkbox"/> Frequent runny nose</p> <p><u>Respiratory</u> <input type="checkbox"/> Cough, short of breath <input type="checkbox"/> Chest tightness, wheeze</p> <p><u>Musculoskeletal</u> <input type="checkbox"/> Muscle pain, weakness <input type="checkbox"/> Joint pain, swelling <input type="checkbox"/> Bone pain</p> <p><u>Other (eye, skin, blood)</u> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Squinting <input type="checkbox"/> "Crossed" eyes <input type="checkbox"/> Itchy eyes <input type="checkbox"/> Rashes <input type="checkbox"/> Abnormal moles <input type="checkbox"/> Abnormal bruising, bleed</p>	<p><u>Gastrointestinal</u> <input type="checkbox"/> Nausea, vomiting, diarrhea <input type="checkbox"/> Constipation, blood in stool <input type="checkbox"/> Abdominal pain</p> <p><u>Cardiovascular</u> <input type="checkbox"/> Chest pain, palpitations <input type="checkbox"/> Tires easily with exertion <input type="checkbox"/> Fainting</p> <p><u>Genitourinary</u> <input type="checkbox"/> Frequent or painful urination <input type="checkbox"/> Bedwetting, frequent accidents <input type="checkbox"/> Vaginal or penile discharge</p> <p><u>Neurologic</u> <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Clumsiness <input type="checkbox"/> Milestone delay</p> <p><u>Psychiatric/emotional</u> <input type="checkbox"/> Anxiety/stress <input type="checkbox"/> Depression <input type="checkbox"/> Sleep problem <input type="checkbox"/> Anger concern <input type="checkbox"/> Concerns with attention, impulsivity</p>
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_____ MD
_____ Date