

PEDIATRIC HEALTH HISTORY Birth to 10 years

Patient's Name: _____
Birthdate: _____ Gender: Male Female
Previous Doctor: _____ City & State: _____
Reason for changing doctors: _____
Person filling out this form: _____ Relationship to patient: _____

PREGNANCY HISTORY

During pregnancy with THIS child, did mother:
Have any illness or medical conditions during pregnancy? No Yes

Need to take any medication during pregnancy? No Yes _____
Use any tobacco? No Yes _____
Drink alcohol? No Yes _____
Use any drugs? No Yes _____

LABOR AND DELIVERY

Was this baby born on their due date? Yes No (how early or late?) _____
Type of delivery: vaginal forceps vacuum assisted C-section (reason): _____
Any problems during labor or delivery? No Yes _____

BIRTH HISTORY

Baby's birth weight: _____
Did this baby have any problems during this hospital stay? No Yes _____
Did mother and baby go home from the hospital together? Yes No (why not?) _____
Hospital/Facility of birth: _____ City/State: _____

INFANT FEEDING

Are/did you breastfeed your baby? No Yes (for how long?) _____
If you are still breastfeeding, how long do you plan to breastfeed? _____

PAST MEDICAL HISTORY

Has your child ever had any of these problems? (please check)

<input type="checkbox"/> Problems seeing or hearing	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Mono	<input type="checkbox"/> Anemia
<input type="checkbox"/> Strep throat	<input type="checkbox"/> Migraines or other headaches
<input type="checkbox"/> Allergies	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Head injury
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other neurologic problems _____
<input type="checkbox"/> Other breathing or respiratory problems _____	<input type="checkbox"/> Broken bones
<input type="checkbox"/> Bladder/kidney infection	<input type="checkbox"/> Stitches
<input type="checkbox"/> Other bladder/kidney problems _____	<input type="checkbox"/> Poisoning
<input type="checkbox"/> Any stomach or digestive problems	<input type="checkbox"/> Burns that needed a doctor's care
<input type="checkbox"/> Any glandular problems (diabetes, thyroid etc)	<input type="checkbox"/> Attention deficit/hyperactivity disorder
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Weight concerns (too much/too little)
<input type="checkbox"/> Other heart problems _____	<input type="checkbox"/> Alcohol /drug use (ever)
	<input type="checkbox"/> Tobacco use (ever)
	<input type="checkbox"/> Any other conditions _____

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Has your child ever spent the night in the hospital (other than birth)? No If so, when and for what? _____

Has your child ever needed surgery? No If so, when and for what? _____

Has your child ever needed to go to the Emergency Department? No If so, when, and for what? _____

Has your child ever had an allergic reaction to food? No Yes

Food	Reaction	Do they require an EpiPen(Jr)?	If so, when does the EpiPen (Jr.) expire?

What medications does your child take? (prescription and over-the-counter)

Medication	Dose	Reason for medication	When started

Has your child ever had an allergic reaction to a medication? If so, what medication, what was the reaction?

Has your child ever been evaluated by any specialists or clinics other than their primary doctor? (eg. psychologists, counselors, physical, occupational or speech therapists?)

Name	Location	Reason for visit	Date last seen

FAMILY MEDICAL HISTORY

If present, please note relationship to patient (e.g. Mother, Brother, Paternal Grandmother)

- Asthma _____
- Allergies _____
- Diabetes Mellitus _____
- Thyroid problems _____
- Sickle cell anemia _____
- Other bleeding or blood disorders (please specify) _____
- Seizures _____
- Migraines _____
- Anxiety _____
- Depression _____
- Attention Deficit/Hyperactivity Disorder _____
- Alcohol/drug abuse _____
- Colitis (Crohn's or ulcerative colitis) _____
- Irritable bowel syndrome _____
- Kidney stones _____

- Other bladder or kidney problems (please specify) _____
- Cancer _____
- Heart attack before 50 years old _____
- Other heart problems (please specify) _____
- High cholesterol _____
- Death of infant or young child _____
- Other medical problems (please specify) _____

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DEVELOPMENT

For children AT LEAST 5 years old, please describe their school progress:

Current grade level: _____ Current school: _____

Ever repeated a grade? No Yes Ever advanced a grade? No Yes

Has your child had any difficulties in school (either socially or academically): No Yes _____

What kind of grade or evaluation does your child usually receive: Excellent Good OK Poor

How does your child feel about their grades? Very pleased Satisfied Unsatisfied

How do you feel about your child's progress? Very pleased Satisfied Unsatisfied

Do you have any concerns about your child's school progress? No Yes

SOCIAL HISTORY

Who lives with this child?:

Full Name:	Age:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child live in any other homes? No Yes

When do they live there? _____

Who lives with them at this home?

Full Name:	Age:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are parents married, unmarried or divorced? (please circle)

Does anyone smoke (inside or outside)? No Yes

(who): _____

We recommend that your child is NOT around any tobacco smoke. Exposure to tobacco smoke can increase your child's risk for "colds", ear infections, bronchitis and acute asthma attacks. It can increase a baby's risk of Sudden Infant Death Syndrome (SIDS).

What are the parents' occupations?

Mother/partner: _____ Father/partner: _____

Does/ will your child attend daycare? No Yes Where & how many days per week? _____

Does your child attend preschool? No Yes Where & how many days per week? _____

Does your child attend an afterschool program? No Yes _____

What kind of hobbies, extra-curricular activities or sports does your child participate in? _____

What does your child want to be when he/she grows up? _____

Is there anything else you would like us to know about your child? _____

Parent Signature: _____

Date: _____

Physician Signature: _____

Date: _____