

## Pediatric Health History



Please answer the following as completely and accurately as possible. This information will aid us in the treatment of your child as well as answer any concerns you might have.

Date: \_\_\_\_\_ Child's Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male or Female (Circle One) Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Child's School: \_\_\_\_\_ Previous Physician \_\_\_\_\_

### ALLERGIES (Drug, Food, Other)

### MEDICATIONS

Substance	Reaction	Medication Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Birth History:

Birth Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Length: \_\_\_\_\_ inches Weeks Gestation: \_\_\_\_\_ wks

Hospital: \_\_\_\_\_ Obstetrician: \_\_\_\_\_

Any problems with the pregnancy or delivery? Please explain: \_\_\_\_\_

Are you breastfeeding? \_\_\_\_\_ If so, how many times a day and how long on each breast?

If bottle feeding, how many oz. per bottle and times per day? \_\_\_\_\_

### General:

Does your child have any serious illness or medical condition? Y or N Explain: \_\_\_\_\_

Has your child had any serious accidents? Y or N Explain: \_\_\_\_\_

Has your child had any surgery? Y or N Explain: \_\_\_\_\_

Has your child ever been hospitalized? Y or N Explain: \_\_\_\_\_

**Development:**

Are you concerned about your child's physical development? Y or N Explain: \_\_\_\_\_

Are you concerned about your child's emotional development? Y or N Explain: \_\_\_\_\_

Are you concerned about your child's attention span? Y or N Explain: \_\_\_\_\_

Other Concerns: \_\_\_\_\_

**Family History:**

Have any family members had the following:

Deafness  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Nasal Allergies  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Asthma  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Tuberculosis  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

berculosis  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Heart Disease  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

High Blood Pressure  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

High Cholesterol  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Cancer  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Anemia  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Liver Disease  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Kidney Disease  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Diabetes  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Epilepsy  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Mental Illness  Yes  No Relationship: \_\_\_\_\_ Comments: \_\_\_\_\_

Other pertinent family history: \_\_\_\_\_

**Past History:**

Does your child have or has he/she ever had:

- |  |                              |                             |                |
|--|------------------------------|-----------------------------|----------------|
| Chicken Pox  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Frequent ear infections                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Problems with ears or hearing                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Nasal Allergies                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Problems with eyes or vision                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Asthma, bronchiolitis, bronchitis, or<br>Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Any heart problem or murmur                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Anemia or bleeding problem                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Frequent abdominal pain                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Constipation                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Urinary tract infections                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Bed-wetting (after age 5)                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Chronic skin problems                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Frequent headaches                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Epilepsy or convulsions                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Diabetes   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Thyroid or endocrine problems                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
| Other significant problems                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain: _____ |
|  |                              |                             | _____          |