PEDIATRIC HEALTH HISTORY

A critical part of your child's medical record is his/her medical history. Your child's overall health as well as any medications your child takes could have an important interrelationship with the healthcare your child receives
Please take the time to answer each of the following questions completely in ink. All answers will be treated confidentially. If there is any question you have difficulty answering, please circle it and the doctor will be happy to discuss it with you.

Personal Information

Patient_____ Birthdate____/____/_____ Patient#_____

Mother's Name_____ Telephone: Home_____Work_____

Father's Name_____ Telephone: Home_____Work_____

☐ Female ☐ Male Birthplace ☐ Home ☐ _____ Hospital ☐ _____

Child lives with_____ Nickname_____
(Mother, Father, Parents, etc.)

Prior Physician_____ Tel/Address_____

Child's School_____ Grade_____ Tel/Address_____

Child's Birth History

Maternal Information During This Pregnancy

Caffeine Use: Type_____ Amt/Day_____
Alcohol Use: Type_____ Amt/Day_____
Tobacco Use: Type_____ Amt/Day_____
Street Drugs: Type_____ Amt/Day_____
Type_____ Amt/Day_____
Type_____ Amt/Day_____

Medications: Non-prescription/Prescription

Type/Strength_____ Amt/Day_____

Type/Strength_____ Amt/Day_____

Type/Strength_____ Amt/Day_____

Type/Strength_____ Amt/Day_____

During the pregnancy did you have:

Prenatal care	No	Yes
High Blood Pressure	No	Yes
Gestational Diabetes	No	Yes
Venereal Disease	No	Yes
German (3 Day) Measles	No	Yes
Exposure to Known Causes of Birth Defects	No	Yes
Any illness, Infection, or High Fever	No	Yes

If yes, describe_____
Was Baby Born: Early(<38 Wks) Term(=38 Wks) Late(42 Wks)

Was Baby: Normal Vaginal Breech (bottom first) C-Section

Please describe any complications:_____

_____

_____

Infant Health History (Birth to Present)

Birth Weight_____lbs_____oz Age when discharged from hospital_____
Was your baby:
Jaundiced No Yes age_____ how long_____

Breast fed No Yes _____ months

Formula fed No Yes _____ months Formula_____

Did your baby…

See a doctor for well baby care	No	Yes
See a doctor for illness/problem	No	Yes
Shots up to date	No	Yes

Describe_____
_____
_____
_____
_____

Health History

Does your child have or has your Child ever had:
(Please Circle)

Mumps, Measles	No	Yes	Developmental Problems	No	Yes
Chicken Pox	No	Yes	Croup	No	Yes
Eczema/Skin Problems	No	Yes	TB/Lung Diseases	No	Yes
Pneumonia	No	Yes	High Blood Pressure	No	Yes
Asthma/Wheezing	No	Yes	Kidney/Bladder Problems	No	Yes
Cancer	No	Yes	Sexually Trans. Disease	No	Yes
Hepatitis	No	Yes	High Cholesterol	No	Yes
HIV/AIDS	No	Yes	Handicaps/Disabilities	No	Yes
Hemophilia	No	Yes	Diabetes	No	Yes
Abnormal Bleeding	No	Yes	Rheumatic Fever	No	Yes
Allergies	No	Yes	Congenital Heart Defect	No	Yes
Frequent Ear Infections	No	Yes	Heart Murmur	No	Yes
Frequent Colds	No	Yes	Convulsions/Epilepsy	No	Yes
Sore Throats	No	Yes	Emotional Disorders	No	Yes
Dental Problems	No	Yes	Suicide Attempts	No	Yes
Bed Wetting	No	Yes	Thumb Sucking	No	Yes
Eye Problems	No	Yes	Toilet Training Problems	No	Yes
Speech Problems	No	Yes	Diarrhea or Constipation	No	Yes
Hearing Problems	No	Yes	Irritable/Temper Problems	No	Yes
Emotional Problems	No	Yes	Nightmares/Sleep Problems	No	Yes
Disciplinary Problems	No	Yes	Feeding/Eating Problems	No	Yes
Meningitis	No	Yes			

Family Health History

Relationship	Age	Age at & Cause of Death
Mother	_____	_____
Father	_____	_____
Siblings	Age(s) of living	Age(s) at death
Male	_____	_____
Female	_____	_____

Family Medical Problems

Please identify any medical problems blood relatives have or ever have had.

Condition	No	Yes	Family Member(s)
Birth Defects	___	____	_____
Genetic Defects	___	____	_____
Mental Retardation	___	____	_____
Allergies	___	____	_____
Lung Disease	___	____	_____
Asthma	___	____	_____
Bone/Joint Disorder	___	____	_____
Rheumatoid Arthritis	___	____	_____
Muscle Disorders	___	____	_____
Skin Disease	___	____	_____
Eye or Ear Disorders	___	____	_____
Cancer	___	____	_____
Diabetes	___	____	_____
Thyroid Disease	___	____	_____
Heart Disease	___	____	_____
Anemia/Blood Disorder	___	____	_____
High Blood Pressure	___	____	_____
Kidney Disease	___	____	_____
Rheumatic Fever	___	____	_____
Tuberculosis (TB)	___	____	_____
Seizures/Convulsions	___	____	_____
Mental Disease/Disorder	___	____	_____
Venereal Disease	___	____	_____
HIV/AIDS	___	____	_____
Other	___	____	_____

Hospitalizations or Serious Illnesses

Please list any hospitalizations, serious and/or unusual illnesses which your child has experienced.

Date	Hospitalizations/Illness	Hospital/Physician's Name	City. State

Medications

Please list all medications your child currently takes.

Date	Medication/Strength	Frequency	Condition

Allergies

Please list allergies, sensitivities, and/or reactions to any drugs.

_____
_____
_____

To the best of my knowledge, the question, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary services my child may need.

_____ _____
Signature of parent or guardian Date

Doctor's Review_____
_____
_____
_____

_____ _____
Doctor's Signature Date

Health History Update **Physicians Use Only**

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____

Date_____ Changes/Comments_____

_____

_____Physician's Signature_____Date_____