PEDIATRIC HEALTH HISTORY 1 to 17 Years of age

Today's Date _____

Child's Name _____ Age _____ Date of Birth_____ Sex : ❒ M ❒ F

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

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

Home Address _____

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
❒ Hayfever
❒ Hepatitis
❒ Immune Deficiency/HIV
❒ Juvenile Diabetes
❒ Measles (10-day)
❒ Measles, Rubella (3-day)
❒ Mumps
❒ Pre-maturity
❒ Rheumatic fever
❒ Pneumonia
❒ Seizures
❒ Sickle Cell Disease
❒ Whooping cough
❒ Other _____

MUSCLE/JOINT/BONE
❒ Broken bones or sprains
❒ Coordination problems
❒ Posture problems
❒ Pain, weakness, swelling in:
- ❒ Arms ❒ Hips
- ❒ Back ❒ Legs
- ❒ Feet ❒ Neck
- ❒ Hands ❒ Shoulders

GENERAL
❒ Chills
❒ Depression
❒ Dizziness
❒ Fainting
❒ Fever
❒ Forgetfulness
❒ Headache
❒ Loss of sleep
❒ Mood Swings
❒ Nervousness
❒ Numbness
❒ Sweating
❒ Tiredness
❒ Weight loss/gain

NOSE/THROAT/CHEST
❒ Difficulty breathing
❒ Difficulty swallowing
❒ Frequent colds
❒ Hoarseness
❒ Mouth-breathing
❒ Nosebleeds
❒ Persistent cough
❒ Sinus Problems
❒ Sore throats
❒ Strep throat
❒ Tonsil infections
❒ Wheezing

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? _____

CARDIOVASCULAR
❒ Breathing problems
❒ Chest pain
❒ Irregular heart beat
❒ Rapid heart beat

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-vagina or penis
❒ Frequent urination
❒ Painful urination
❒ Unusual urine odor

SKIN
❒ Bruise easily
❒ Change in moles
❒ Hives
❒ Itching
❒ Rash
❒ Scars
❒ Sores that won't heal

Hospitalizations / Surgeries

Reason	Date	Hospital, City, State

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

Injuries / Illnesses

Serious Injuries/Illnesses	Date	Outcome

Family History

Check ☑ if the child's blood relatives had any of the following.

	Father	Mother	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma/emphysema	☐	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐	☐
Bone/joint disorders	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐
Eye or ear disorders	☐	☐	☐	☐	☐
Genetic defects	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Hemophilia	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐

	Father	Mother	Siblings	Father's Parents	Mother's Parents
Kidney disease	☐	☐	☐	☐	☐
Loss of hearing, Blindness	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐
Mental disease/disorder	☐	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Muscle disorders	☐	☐	☐	☐	☐
Rheumatic fever	☐	☐	☐	☐	☐
Seizures/convulsions	☐	☐	☐	☐	☐
Sickle cell anemia	☐	☐	☐	☐	☐
Skin disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Veneral disease	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

Father's Age _____ General Health _____ Mother's Age _____ General Health _____

Education & 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 a 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?

Angry behavior	☐ Yes	☐ No
Changes in appearance	☐ Yes	☐ No
Changes in attitude	☐ Yes	☐ No
Changes in friendships	☐ Yes	☐ No
Changes in eating habits	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Signs of drugs in the house	☐ Yes	☐ No
Skipping school	☐ Yes	☐ No
Withdrawal from friends and family	☐ Yes	☐ No
Changes in sleeping patterns	☐ Yes	☐ No

Immunizations

Please check ☑ if series is completed

Hepatitis B, series of 3	☐ Yes	☐ No
DPaT, series of 5	☐ Yes	☐ No
DPaT booster shot	☐ Yes	☐ No
HIB, series of 4	☐ Yes	☐ No
Polio, series of 3	☐ Yes	☐ No
MMR, series of 2	☐ Yes	☐ No
Chicken Pox series of 1 or 2	☐ Yes	☐ No
Prevnar (pneumococcal), series of 3	☐ Yes	☐ No
Flu (Influenza)	☐ Yes	☐ No
Gardisil (HPV), series of 3	☐ Yes	☐ No
Td (Tetanus) booster	☐ Yes	☐ No
TB skin test	☐ Yes	☐ No

Other

Please list any other problems not covered in this questionnaire

_____

_____

_____

_____

_____

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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 child ever has a change in health.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print the name of Parent, Guardian or Personal Representative Relationship to Patient

OFFICE USE ONLY

_____
Reviewed by

_____
Date