Children's Medical Group, P.A.
Pediatric Health History Form

Patient Name:______________________________ Date of Birth: _______________ Age: _______

Your Name: ________________________________

Your relationship to child:__________________________

Child's previous doctor/primary care provider: _____________________________

Present health concerns:

____

Medicines/Vitamins:___________________________

Herbs/Home Remedies:_________________________

Allergies/Reactions to medicines or vaccinations:_______________________

PREGNANCY & BIRTH

Where was your child born? ____________________

Is the child yours by: ☐Birth ☐Adoption ☐Stepchild ☐Other: __________

Please indicate any medical problems during pregnancy

☐None ☐Specify: ______________________

Delivery by: ☐Vaginal birth ☐Caesarean

If Caesarean, why? ___________________________

Birth weight: __________ Birth length: _________

Please indicate any medical problems during the baby's newborn period ☐None (If premature, how early?)

____

Other problems:

____

NUTRITION & FEEDING

Your child breastfed? ☐No ☐Yes

If so, how long? _______________

☐Formula Brand:_______________

Has your child had any unusual feeding/dietary problems?

☐No ☐Yes If yes, specify: ________________

Milk intake now: Type ☐Cow's milk (☐Nonfat ☐1% fat ☐2% fat ☐Whole) ☐Soy milk ☐Rice milk ☐Breast milk

Average ounces per day (Note: 8 ounces = 1 cup)

____

SLEEP

Hours per night _________________

Naps (number & length) _______________

Any sleep problems? _______________

DEVELOPMENT

At what age did your child: Sit alone _________

Walk alone __________ Say words __________

Toilet train (daytime) __________

Girls only: Age at first menstrual period __________

DENTAL HISTORY

Has child been seen by a dentist? ☐No ☐Yes

If so, how often? ______________________

Date of last visit ______________________

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:

☐Chickenpox ☐Measles ☐Mumps

☐Rubella ☐Meningitis ☐Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint) ☐No ☐Yes

Do any household members smoke? ☐No ☐Yes

TV – hours per day __________

Computers – hours per day __________

Video games – hours per day __________

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

____

____

____

____

Hospitalization/operations (with dates): ______________________________

Broken bones or severe sprains: ______________________________

FAMILY HISTORY

Please indicate any deaths of your immediate family members: ______________________________

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism/Drug abuse ______________________________

High cholesterol ______________________________

Cancer, specify type ______________________________

High blood pressure ______________________________

Heart disease ______________________________

Kidney disease ______________________________

Psychiatric disorders ______________________________

Bleeding or clotting disorder ______________________________

Genetic disorders/Birth defects ______________________________

Asthma ______________________________

Diabetes ______________________________

Thyroid disorder ______________________________

Seizures ______________________________

Other: ______________________________

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship

Are your child's parents ☐Married ☐Unmarried ☐Separated ☐Divorced

If divorced or separated, when? ______________________________

Mother's Occupation ______________________________

Mother's Employer ______________________________

Father's Occupation ______________________________

Father's Employer ______________________________

Child care situation ☐Parents ☐Others (specify who and how often) ______________________________

Concerns about your child: ☐Alcohol use ☐Tobacco ☐Sexual Activity ☐Aggressive Behavior

Is violence at home a concern? ☐No ☐Yes

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐No ☐Yes

Current grade ______________________________

Name of school ______________________________

Any concerns about school performance? ______________________________

Any concerns about relationship with:

Teachers ☐No ☐Yes

Peers ☐No ☐Yes

If more than 4 years old: does your child have a best friend? ☐No ☐Yes

Sports/exercise: Type ______________________________

How often? ______________________________

How long (minutes)? ______________________________

REVIEW OF SYMPTOMS:

Please check any current problems your child has on the list below:

General

___ Fevers/chills/excessive sweating

___ Unexplained weight loss/gain

Eyes

___ Squinting/"crossed" eyes/ asymmetric gaze

Ears/Nose/Throat

___ Unusually loud voice/hard of hearing

___ Mouth breathing/snoring

___ Bad breath

___ Frequent runny nose

___ Problems with teeth/gums

Cardiovascular

___ Tires easily with exertion

___ Shortness of breath

___ Fainting

Respiratory

___ Cough/wheeze

___ Chest pain

Gastrointestinal

___ Nausea/vomiting/ diarrhea

___ Constipation

___ Blood in bowel movement

Genitourinary

___ Bedwetting

___ Pain with urination

___ Discharge: penis or vagina

Musculoskeletal

___ Muscle/joint pain

Skin

___ Rashes

___ Unusual moles

Allergy

___ Hay fever/itchy eyes

Neurological

___ Headaches

___ Weakness

___ Clumsiness

Psychiatric/Emotional

___ Speech problems

___ Anxiety/stress

___ Sleep issues

___ Depression

___ Nail biting/thumb sucking

___ Bad temper/breath holding/jealousy

Blood/Lymph

___ Unexplained lumps

___ Easy bruising/bleeding