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:_____

Type of Current Milk Intake now:

☐ Cow's milk ☐ Nonfat ☐ 1% fat ☐ 2% fat

☐ Whole ☐ Soy milk ☐ Rice milk ☐ Breast milk

Average ounces per day (Note: 8 oz = 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 your 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:_____

_____

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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_____

Kidney disease_____

Psychiatric disorders_____

Bleeding or clotting disorder_____

Genetic disorders/Birth defects_____

Asthma_____

Diabetes_____

Thyroid disorder_____

Seizure_____

Other:_____

SOCIAL HISTORY

Who lives at home?

Name Age Relationship to child

_____

_____

_____

_____

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 ☐ Other (specify who and how often) _____

Concern 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 over 4 yrs 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 gain/loss

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

Neurological
___ Headaches
___ Weakness
___ Clumsiness

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

Cardiovascular
___Tires easily with exertion
___ Shortness of breath
___ Fainting

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