

Pediatric Health History

Date of Visit: _____ Date of Birth _____
 Child's Name: _____
 Your Name: _____
 Relationship to Child: _____

Reason for visit? _____

Date of last physical exam: _____
 Child seen by another primary care physician or other health care providers?

Vital Information:

Child's Birth date _____ Gender Boy Girl
 Birthplace: City/State _____
 Home Hospital / Birth Center _____
 Parent's Name _____ Birth date: _____
 Occupation _____ Height _____
 Parent's Name _____ Birth date: _____
 Occupation _____ Height _____
 Other members of the household _____ Birth dates _____

Any pets? _____ Age of home/apt _____

Was child adopted? Yes No At what age? _____
 If adopted, country of origin _____

Religious Preference _____

Pregnancy History

Number of pregnancies before this one: _____
 How long was this pregnancy? _____ weeks
 How many months pregnant when prenatal care was begun? _____
 Were there any of the following conditions in pregnancy?
 Rubella (measles) Accident / Injury Bleeding
 High blood pressure Swelling Sugar in urine
 Excessive weight gain Other infections twins/triplets....

Explain: _____

Medicines or supplements used during pregnancy:

Smoking while pregnant: None Moderate Heavy

Alcohol while pregnant: None <1 per week >1 per week

Birth Information

How long was labor? _____ Was labor induced? _____

At delivery (check all that apply):

vaginal birth Vacuum/forceps Cesarean Breech
 Breathed spontaneously Resuscitated delayed cord clamping
 Immediate cord clamping

Did baby require:

special nursery transfusion antibiotics lights oxygen

Did baby have:

breathing problems jaundice Other _____

At birth:

Weight: _____ Length: _____ Apgar scores _____

Discharge weight: _____ Length of hospital stay: _____

Did baby receive Vit K Hep B vaccine newborn screening tests

Describe any problems with birth or first days of life _____

Family Background

Parents are:
 Married Living together Separated Divorced Single

Child lives with:
 Both biological parents Guardian: _____

Other family structure _____

Ethnic origin/Race of biological parents

Mother: _____ Father: _____

Genetic relative	Health problems	Living: Current age	Deceased: Age at death
mother			
father			
maternal grandma			
maternal grandpa			
paternal grandma			
paternal grandpa			
maternal aunt/uncle			
Paternal aunt/uncle			
Sibling M / F			
Sibling M / F			
Sibling M / F			
Sibling M / F			
Sibling M / F			
other			

Infant Nutrition

- Breastmilk Duration _____ weeks / months / years
 Avg number of nursing episodes/24 hours, currently _____
 Formula Brand _____ Oz/day _____ Age of first use _____
 Uses Pacifier Uses Bottle **Solid foods:** Age when started _____

Childhood Nutrition:

What has your child eaten over the past day?
 Breakfast: _____
 Lunch _____
 Dinner _____
 Snacks _____
 Fluids _____

What are your child's favorite foods in each category:

Protein foods: _____
 Fruits: _____
 Vegetables: _____
 Grains: _____

Sleep and Elimination

Bowel movements: _____
 Urination/day or wet diapers/day: _____
 Where/with whom/ how does child sleep?
 Shared room or bed? Crib? Cosleeper? Bunk bed? On tummy or back?

 Typical Bedtime: _____ Wake time: _____ #wakings/night _____
 Naps: _____
 Sleep problems? _____

Medical history

Please check the diseases that your child has had and give age:

- Measles, Rubella _____ Anemia _____
 Mumps _____ Heart Disease _____
 Chickenpox _____ Allergies / Hay fever _____
 Whooping cough _____ Eczema _____
 Scarlet fever _____ Asthma _____
 Rheumatic fever _____ Pneumonia _____
 Convulsions/Seizures _____ Hepatitis _____
 Strep throat _____ Ear Infection _____
 Other Medical conditions: _____

Has your child ever been seriously injured? _____ Age _____
 Injury: _____
 Any fractures? _____ Which bone(s)? _____
 Any loss of consciousness or concussion? _____
 Any accidental poisoning? _____ Age _____ Substance _____
 Has your child ever had surgery? _____ Age _____
 Type of operation _____
 Has your child ever been hospitalized other than for the above? _____
 Describe: _____
 Has your child ever had a blood transfusion? _____ Age _____

Has your child worn:

- Glasses Contact lenses Dental braces Leg braces
 Corrective shoes Orthotics in shoes Other braces

Please list all medications and supplements:

Does your child have allergies to any of the following?

- Drugs _____
 Foods _____
 Environment _____

Please check if your child has:

- Frequent headaches Crossed eyes
 Projectile vomiting More than two earaches a year
 Trouble hearing frequent nosebleeds
 Stuffy nose most of time More than 6 colds a year
 Chronic cough Shortness of breath with exercise
 Heart murmur Constant or frequent fatigue
 Frequent stomachaches Frequent diarrhea or constipation
 Poor appetite Frequent urination or accidents
 Bloody, red, or brown urine Frequent bed-wetting after age 5
 Joint pains or swelling Dizziness or fainting spells
 Inability to get to sleep Frequent nightmares or sleepwalking
 Excessive thirst Excessive weight gain
 Signs of sexual development before age 9

Other concerns:

Child Development

At what age did your child:

Sit alone _____ Walk alone _____ Feed self _____
 Talk (2-3-word sentences) _____ Dress self _____
 Toilet trained: Day _____ Night _____

School-age child: Current grade _____ Days missed this year _____

School Problems: reading, writing behavior special needs

Are there any behavior problems at home? _____

Please describe: _____

Immunizations and Screenings

- Immunizations up to date on standard schedule
 Selective immunizations delayed schedule
 non-immunized copy of immunization record provided

Please give approximate dates for the following, if done:				
Test	No	Yes	Date(s)	Result
Lead blood test				
Dental visit				
Vision exam				
Hearing test				
Anemia test				
Urine test				
Other:				