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			
Sibling M / F			
Sibling M / F			
Sibling M / F			
Sibling M / F			
Sibling M / F			
Sibling M / F			
other			
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:				