CHART #

Pediatric Health History Form – Initial Visit

Child's Name ________________________ Date of Birth ______________ Age ____________

Your Name ________________________ Relationship to Child ________________________

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? ____________________

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications ____________________

Delivery by ☐vaginal ☐c-section

Reason for c-section ____________________

Complications ____________________

Was your child premature ☐No ☐Yes, born at __________ weeks

Complications ____________________

Apgar scores 1 minute _________ 5 minutes ______________

Birth weight _________________ Length ________________

Other problems in the newborn period ________________________

____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease ____________________
- ☐ Wheezing or bronchiolitis ____________________
- ☐ Seasonal allergies or eczema ____________________
- ☐ Food allergy ____________________
- ☐ Recurrent ear infections ____________________
- ☐ Pneumonia ____________________
- ☐ Urinary tract infections ____________________
- ☐ Genetic syndrome ____________________
- ☐ Seizures ____________________
- ☐ Anemia ____________________
- ☐ Broken bone ____________________
- ☐ Mental retardation or learning disability ________________
- ☐ Depression/anxiety ____________________

Other chronic medical conditions ________________________

____

____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

____

____

Previous surgeries and dates ____________________________

____

Please list any specialist your child is currently seeing and reason:

____

____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

____

____

____

Current medications and dose: ____________________________

____

____

Vitamins ________________________________

Herbal supplements ________________________________

Over-the-counter meds ________________________________

Development/Nutrition

At what age did your child: Sit alone _______________

Walk alone ______________ Say words ______________

Toilet train(day) __________ 1st period (females) _______

Was your child breastfed ☐ No ☐Yes, how long? ________

Has your child had any unusual feeding/dietary problems? Explain.

____

Current milk intake: Type ____________ Amount __________oz/d

Created 12/2006

Social History

Who lives in the household with the child? ☐ Mom ☐ Dad ☐ Siblings (# _____) ☐ Grandparents ☐ Other ___________

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) ______________

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _______Computer _______Video games ______

Child's school name _________________________ Grade ______

Any concerns about school performance? ☐ No ☐ Yes, explain

____

Any concerns about peer or teacher relationships? ☐ No ☐ Yes

____

Sports/exercise: Type ________________________________

How often? _________________ How long ___________min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
______________	☐	☐	☐	☐

Please explain all positives. ____________________________

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____

____

____

Review of Systems (*Check all that apply*)

Constitutional
- ☐ Fever, chills ☐ Fatigue
- ☐ Unexplained weight loss/gain
- ☐ Excessive thirst

Ear, Nose, and Throat
- ☐ Loud voice, hearing problem
- ☐ Mouth-breathing, snoring
- ☐ Ear pain
- ☐ Frequent runny nose

Respiratory
- ☐ Cough, short of breath
- ☐ Chest tightness, wheeze

Musculoskeletal
- ☐ Muscle pain, weakness
- ☐ Joint pain, swelling
- ☐ Bone pain

Other (eye,skin,blood)
- ☐ Blurry vision ☐ Squinting
- ☐ "Crossed" eyes ☐ Itchy eyes
- ☐ Rashes ☐ Abnormal moles
- ☐ Abnormal bruising, bleed

Gastrointestinal
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation, blood in stool
- ☐ Abdominal pain

Cardiovascular
- ☐ Chest pain, palpitaions
- ☐ Tires easily with exertion
- ☐ Fainting

Genitourinary
- ☐ Frequent or painful urination
- ☐ Bedwetting, frequent accidents
- ☐ Vaginal or penile discharge

Neurologic
- ☐ Headaches ☐ Seizures
- ☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
- ☐ Anxiety/stress ☐Depression
- ☐ Sleep problem ☐ Anger concern
- ☐ Concerns with attention, impulsivity

Reviewed by _______________________ ***date*** ____________

________________________MD

Date