

## Pediatric Health History Form- Page 1 of 2

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Your relationship to child: \_\_\_\_\_

Chronic (daily) medications

Child's previous doctor/primary care provider: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any chronic medical problems, such as asthma:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Hospitalizations:  
 none  specify: \_\_\_\_\_

Allergies:  
 none  specify: \_\_\_\_\_

Specialists involved (example, pulmonologist for asthma)  
 none  specify: \_\_\_\_\_

Pregnancy & Birth:  
Birth hospital or place of birth: \_\_\_\_\_

Severe illnesses, injuries, broken bones, etc.  
 none  specify: \_\_\_\_\_

Is the child yours by:  
 birth  adoption  
 stepchild  other: \_\_\_\_\_

Immunizations/Vaccines:  
 up to date  delayed  
 I have concerns about vaccines

Mother's age at the birth of child: \_\_\_\_\_

Has your child been seen by a dentist?  
 yes  no  
date of last visit: \_\_\_\_\_

Please indicate any problems during pregnancy  
 none  specify: \_\_\_\_\_

Do you have any concerns about your child's development?  
 none  delayed  
 problems with talking  
 problems with behavior  
 school/academic concerns  
 other concerns \_\_\_\_\_

Please list any medications other than vitamins  
 none  specify: \_\_\_\_\_

Pregnancy duration:  
 full-term (38-42 weeks)  
 premature, specify: \_\_\_\_\_ weeks

Birth Weight: \_\_\_\_\_

Delivery by:  
 vaginal  C-section  
reason for C-section \_\_\_\_\_

When was your child's last well check-up?  
\_\_\_\_\_

Apgars scores:  
1 min: \_\_\_\_\_ 5 min: \_\_\_\_\_

Problems in the birth hospital (jaundice, fever, etc)  
 none  specify: \_\_\_\_\_

Please list any other concerns you have about your child.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note other important pregnancy & birth facts:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Family History

Are the child's parents alive and in good health?
[ ] yes [ ] specify: \_\_\_\_\_

Are the child's siblings alive and in good health?
[ ] yes [ ] specify: \_\_\_\_\_

Does your child have any brothers or sisters?

Name age relationship (note if step- or half-sibling)

Blank lines for listing family members.

Please list any of your child's blood relatives who have any of the following medical conditions:

- List of medical conditions with checkboxes: AIDS/HIV, Alcoholism, Allergies/Asthma, Arthritis, Blood disorders, Cancer, Cystic Fibrosis, Diabetes, Drug problems, Genetic problems/birth defects, Heart attacks/heart disease, High blood pressure, High cholesterol, Epilepsy/seizures, Kidney disease, Liver disease/Hepatitis, Lung disease, Lupus/other autoimmune diseases, Mental illness, Muscular dystrophy, Obesity, SIDS, Stroke, Tuberculosis, Other.

Social History

Who lives at home?

Table with columns: Name, relationship to child, age. Includes blank lines for entries.

Are your child's parents:

- Checkboxes for: married, unmarried, separated, divorced.

if divorced or separated, when? \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Father's occupation: \_\_\_\_\_

Guardian's occupation: \_\_\_\_\_

Where is the child during the day?

- Checkboxes for: parents or guardian, babysitter/daycare, preschool/school.

Grade: \_\_\_\_\_

School: \_\_\_\_\_

Do any of the adults living with the child smoke?

[ ] no [ ] yes Outside? \_\_\_\_\_

Is there a gun in the home?

[ ] no [ ] yes Locked? \_\_\_\_\_

Is there a pool on your property?

[ ] no [ ] yes Fenced? \_\_\_\_\_

Are there any pets in the home?

[ ] no [ ] yes \_\_\_\_\_

Does the child use a carseat in the car?

[ ] no [ ] yes

Is there any violence in the home?

[ ] no [ ] yes

Has the child witnessed or suffered abuse?

[ ] no [ ] yes