PEDIATRIC HEALTH HISTORY

Date _____
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Our healthcare team will strive to provide your child with the best possible healthcare. A critical part of your child's medical record is his/her medical history. Your child's overall health as well as any medications which your child takes could have an important interrelationship with the healthcare your child receives.

Please take the time to answer each of the following questions completely in ink. All answers will be treated confidentially. If there is any question you have difficulty answering, please circle it and the doctor will be happy to discuss it with you.

Personal Information

Patient _____ Birthdate ____/____/____ Patient # _____

Mother's Name _____ Telephone: Home _____ Work _____

Father's Name _____ Telephone: Home _____ Work _____

☐ Female ☐ Male Birthplace: ☐ Home ☐ _____ ☐ Hospital _____

Child lives with _____ Current Physician _____
(Mother, Father, Parents, etc.)

Prior Physician _____ Tel/Address _____

Child's School _____ Grade _____ Tel/Address _____

Current Medical Problem(s)

Please list the medical problems(s) which your child is experiencing now.

Reason for visit/problem(s)	Date problem(s) began

Is your child currently being treated for any other medical condition or illness?

Condition or illness	Physician/address	Date beginning treatment

Is your child currently taking any medications?

Medication	Strength	Frequency	Condition

Vitamins/Iron Or Fluoride Supplements	Strength	Frequency

Serious Illnesses, Injuries, Hospitalizations

Please list all serious illnesses, injuries, surgeries and hospitalizations.

Year	Illness, Injury, Surgery	Hospital, City, State

Immunization History

	Date	Date	Date	Date	Date
DPT *(Diphtheria, Whooping Cough, Tetanus)*	____/____	____/____	____/____	____/____	____/____
OPV *(Oral Polio)*	____/____	____/____	____/____	____/____	____/____
MMR *(Measles, Mumps, Rubella)*	____/____	____/____			
Measles	____/____				
HIB *(Haemophilus Influenzae B)*	____/____	____/____	____/____	____/____	____/____
Td *(Adult Tetanus Toxoid)*	____/____	____/____			
Hepatitis B	____/____	____/____	____/____		
Flu	____/____	____/____	____/____	____/____	____/____
Pneumonia	____/____	____/____	____/____	____/____	____/____
PPD *(TB Tine Test)*	____/____	____/____	____/____	____/____	____/____
Please circle result	+ -	+ -	+ -	+ -	+ -

PEDIATRIC HEALTH HISTORY (CONT.)

Patient_____ Birthdate ____/____/____ Patient # _____

Family Health History

Relationship	Age	Age at & cause of death
Mother	____	_____
Father	____	_____

Siblings	Ages, if living	Age at death
Male	____ ____ ____ ____	____ ____ ____
Female	____ ____ ____ ____	____ ____ ____

Family Medical Problems

Please identify any medical problems blood relatives have or ever have had.

Condition	No	Yes	Family members
Birth Defects	____	____	_____
Genetic Defects	____	____	_____
Mental Retardation	____	____	_____
Allergies	____	____	_____
Lung Disease	____	____	_____
Asthma	____	____	_____
Bone/Joint Disorders	____	____	_____
Rheumatoid Arthritis	____	____	_____
Muscle Disorders	____	____	_____
Skin Disease	____	____	_____
Eye or Ear Disorders	____	____	_____
Cancer	____	____	_____
Diabetes	____	____	_____
Thyroid Disease	____	____	_____
Heart Disease	____	____	_____
Anemia/Blood Disorders	____	____	_____
High Blood Pressure	____	____	_____
Kidney Disease	____	____	_____
Rheumatic Fever	____	____	_____
Tuberculosis (TB)	____	____	_____
Seizures/Convulsions	____	____	_____
Mental Disease/Disorder	____	____	_____
Venereal Disease	____	____	_____
HIV/AIDS	____	____	_____
Other_____	____	____	_____

Child's Eating Habits

_____ # of meals each day
_____ # of snacks each day

How often does your child eat or drink:
(I.E., 3/Day, 1/Day, 3/Week, Never, Etc.)

_____ Fruit/Fruit Juice
_____ Cereals *(hot, cold)*
_____ Milk, Cheese, Dairy Products
_____ Eggs
_____ Meat, Poultry, Fish
_____ Beans *(kidney, soybeans, lentils)*
_____ Green vegetables *(green beans, spinach, etc.)*
_____ Yellow vegetables *(carrots, squash, etc.)*
_____ Potatoes, rice, starches *(noodles, pasta, etc.)*
_____ Sweets *(candy, soft drinks, etc.)*
_____ Food supplements *(wheat germ, etc.)*

Is there fluoride in the drinking water? ☐ No ☐ Yes

Maternal Information During This Pregnancy

Caffeine use: Type _____ Amt/Day _____
Alcohol use: Type _____ Amt/Day _____
Tobacco use: Type _____ Amt/Day _____
Street Drugs: Type _____ Amt/Day _____
Type _____ Amt/Day _____
Type _____ Amt/Day _____

Medications: Non-prescription
Type/Strength _____ Amt/Day _____
Type/Strength _____ Amt/Day _____
Type/Strength _____ Amt/Day _____

Prescription
Type/Strength _____ Amt/Day _____
Type/Strength _____ Amt/Day _____
Type/Strength _____ Amt/Day _____
Type/Strength _____ Amt/Day _____

During the pregnancy did you have:

Prenatal Care	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
Gestational Diabetes	☐ No	☐ Yes
Venereal Disease	☐ No	☐ Yes
German (3 Day) Measles	☐ No	☐ Yes
Exposure to Known Cause of Birth Defects	☐ No	☐ Yes
Any Illness, Infection, or High Fever	☐ No	☐ Yes

If yes, describe_____

Was Baby Born: ☐ Early (<38) ☐ Term (38-42 Wks) ☐ Late (42 Wks)
Was Baby: ☐ Normal Vaginal ☐ Breech (bottom First) ☐ C-Section
Please describe any complications: _____

Infant Health History (Birth to 3 Months)

Birth weight_____lbs_____oz
Age when discharged from hospital_____
Was your baby...
Jaundiced ☐ No ☐ Yes, age____how long_____
Breast fed ☐ No ☐ Yes,____months
Formula fed ☐ No ☐ Yes,____months Formula_____
Did your baby...
See a doctor for well baby care ☐ No ☐ Yes
See a doctor for illness/problem ☐ No ☐ Yes
Describe _____

Developmental History

At what age did your child:

_____Mo.	Lift Head
_____Mo.	Roll Over
_____Mo.	Sit Up
_____Mo.	Stand Up
_____Mo._____Yr.	Walk
_____Mo._____Yr.	Drink From Cup
_____Mo._____Yr.	Toilet Train
_____Mo._____Yr.	Remember Name
_____Mo._____Yr.	Dress Alone

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