



Pediatric Health History

All information in this questionnaire is confidential and will be of your child's medical record.

Patient's Full Name: _____ Date: _____

Last, First, MI

Date of birth: _____ Sex: MALE / FEMALE

Other Healthcare Practitioners:

name type of practice phone no.

List your **current health concerns** for your child, in order of their importance to you:

concern date of onset

- 1. _____
- 2. _____
- 3. _____

Traumas, car accidents, injuries? YES / NO (list details)

Surgeries and Hospitalizations:

date reason hospital

Has your child ever had a blood transfusion? YES / NO

Prenatal History: Did mother have any problems or illness during pregnancy? YES / NO

describe: _____

Birth History: Vaginal / Cesarean / Forceps / Vacuum / Trauma?

On time -or- Before 37 weeks of pregnancy -or- After 42 weeks of pregnancy?

Any newborn problems? jaundice / hospitalization / other (describe)

Illness: Has your child had antibiotics? _____ If so, how many times? _____

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Diet

Describe your baby's diet? breastmilk only / formula / mixed

If your child is eating solids, describe what she/he has eaten in the last 24 hours:

Past Medical History - Does your child have, or has she/he had:

	YES	NO		YES	NO
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Constipation requiring a doctor visit	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Bladder or kidney infection	<input type="checkbox"/>	<input type="checkbox"/>
Problems with ears or hearing	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting (if over 5 years old)	<input type="checkbox"/>	<input type="checkbox"/>
Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	(girls) Started menstruating?	<input type="checkbox"/>	<input type="checkbox"/>
Problems with eyes or vision	<input type="checkbox"/>	<input type="checkbox"/>	(girls) Any problems with periods?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, bronchitis, croup or pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurrent skin problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems or murmur	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or bleeding problem	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or other neurological problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>

Family History - Is your child adopted? YES / NO

Have any family members had the following? If so, note the relationship to the child.

	YES	NO		YES	NO
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Allergies / Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes before age 50	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting after age 10	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease before age 50	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure before age 50	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Developmental disability	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>

Social History - the home environment

How many children in your home? _____ Child's birth order (3rd of 4)? _____

What adults live with your child? _____

Has your child had any traumas or losses? _____
