



Please fill out and return.

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

Parents/Guardians Please check-mark which phone number we can leave a message on, identifying ourselves by the clinic name or doctor's name.

name: _____ name: _____

address: _____ address: _____

hm phone: _____ hm phone: _____

email: _____ email: _____

other phone: _____ other phone: _____

In case of emergency and neither parent can be reached, contact:

name: _____ relationship: _____

phone numbers: _____

Pediatrician name: _____ office phone: _____

Can we contact them if we need to? YES / NO

Other Healthcare Practitioners:

name	type of practice	phone no.
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Health Concerns

date of onset

major concern: _____

other concern: _____

other concern: _____

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

Pediatric Health History

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?

Immunizations (include dates if known)

DTP _____	Hep B _____
Polio _____	MMR _____
Hib _____	Chickenpox (Varicella) _____
other _____	_____

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:

Favorite foods & how often eaten? _____

Pediatric Health History

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

Siblings (name)	age	general health
_____	_____	poor fair good
_____	_____	poor fair good
_____	_____	poor fair good

What adults live with your child? _____

Has your child had any traumas or losses? _____

What type of pets do you have: _____

Does anyone smoke in the house? YES / NO _____

How many hours of TV or Computer Games per day? _____

Favorite activities? _____

School Age Children

Has he/she ever been "held back" or had to repeat a grade? YES / NO _____

Are you concerned about your child's attention span? YES / NO _____

Does your child like school? YES / NO _____

Any concerns about your child's behavior in school? YES / NO _____

Any concerns about how he/she is doing academically? YES / NO _____

Anything else we should know about your child? _____

Medications

Please list all current prescription medications, over the counter drugs, vitamins, herbs, homeopathic medicines, etc.

start date	name	dose/strength	frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

name of drug, environment or food allergy	reaction
_____	_____
_____	_____
_____	_____
_____	_____