Pediatric Health History

Please complete all questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete any answers or provide additional information.

Patient: _____ Date of Birth: ___/___/____

School or daycare Attending: _____

Grade in school _____

Who does the patient Live with at Home? _____

Does your child have siblings or ½ siblings that do <u>not</u> live with him/her? ❑Yes ❑No
If Yes, please list gender & ages: _____

<u>MEDICAL CONDITIONS</u>

If either the patient or a family member has or had any of these conditions, check (✓) the box by the condition listed. For family member, indicate their relationship *<u>to the patient</u>* (e.g. Maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM), paternal grandfather (PGF), mother, father, sibling, cousin, maternal aunt, paternal uncle, etc.)

Condition	The Patient	Family Member	Relationship to Child
Allergies/hay fever			
ADD/ADHD			
Asthma			
Cancer (type)			
Depression			
Diabetes			
Hearing Loss			
Heart Problems			
High Blood Pressure			
High Cholesterol			
Kidney Problems			
Migraine Headaches			
Panic Attacks/anxiety			
Seizures			
Skin Problems			
Thyroid problems			
Other:			
Other:			

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BIRTH HISTORY:

Was the patient born prematurely? ❑YES ❑NO If Yes, how early? _____

How was the patient born? ❑ Vaginally ❑By C-Section, if c-section, why? _____

Birth Weight: _____

Did the patient have to stay in the hospital longer than the mother after birth? ❑ YES ❑ NO
IF Yes, how long?_____

Before the patient was born, did mother have any complications of pregnancy?

❑Gestational Diabetes ❑High blood pressure/preeclampsia ❑Alcohol use

❑Illicit drug use ❑Sexually transmitted infection(s), specify _____

❑Other complications of pregnancy _____

****

HOSPITALIZATIONS

Has the patient ever been re-admitted to the hospital since birth for any reason? ❑ YES ❑ NO

If yes, when and for what reason? _____

ALLERGIES

Is the patient allergic or intolerant to any medications or foods? ❑Yes ❑No

If YES, please specify substance(s) and reaction(s)

_____

SURGERIES

Has the patient ever had surgery? ❑Yes ❑No

Please list any surgeries or procedures your child has had with approximate dates:

_____

MEDICATIONS

Please list any medications the patient is using including over the counter medications, vitamins, herbal supplements and contraception:

MEDICATION	DOSE/AMOUNT	HOW MANY TIMES PER DAY

Pediatric Health History

CURRENT SYMPTOM CHECK LIST

If the patient has recently noted any of the following problems, please check (✓) the box by the condition listed.

General	❑Fever ❑Unintended Weight Change (How much weight gained or lost)_____	❑Chills ❑Malaise or "Feeling Ill" ❑Fatigue
Head	❑Headache ❑Dizziness	❑Head Injury
Ears	❑Ear Pain ❑Ear Discharge	❑Change in Hearing ❑Blockage
Nose	❑Congestion ❑Persistently Discolored Discharge ❑Sinus Pressure	❑Clear Discharge ❑Post Nasal Drip ❑Sinus Pain
Throat	❑Sore Throat ❑Laryngitis ❑Itchy Throat	❑Dental Problem ❑Persistent Hoarseness ❑Snoring ❑Sleep Apnea
Eyes	❑Change in Vision ❑Flashing or Scintillating Lights ❑Eye Pain	❑Eye Discharge ❑Itchy or Irritable
Heart	❑Chest pain or Pressure	❑Palpitations/ Racing Heart
Lungs	❑Trouble Breathing ❑Cough	❑Wheezing ❑Painful breathing
Digestive	❑Heartburn or Acid Reflux ❑Nausea ❑Diarrhea ❑Blood in Stool ❑Excessive bloating or Gas	❑Abdominal Pain ❑Vomiting ❑Constipation ❑Black Tarry Stool
Bones & Joints	❑Back Pain ❑Joint Pain	❑Neck Pain ❑Muscle Aches
Neurological	❑Weakness ❑Abnormal Sensations ❑Seizures	❑Numbness ❑Fainting
Psychological	❑Anxious ❑Feeling Hopeless or Helpless ❑Unable to Enjoy Life ❑Uncontrollable Anger or Irritability ❑Wanting to Hurt Someone ❑ Self injury/ cutting/ suicide attempts	❑Panic Attack ❑Persistent Sadness ❑Insomnia ❑Poor Appetite or Stress Eating
Skin	❑Abnormal or Changing Mole ❑Hair or Nail Changes ❑Bruising	❑Rashes ❑Dryness

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PREVENTIVE HEALTH

Please note that Pediatrics includes care of children up to the age of 21. If these questions do not apply to your child, please write, "N/A"

Are the patient's immunizations up to date? ☐ Yes ☐ No **Did the patient get the flu vaccine this flu season? ☐ Yes ☐ No** **When was the patient's last well child exam or physical? _____** **Does the patient drink caffeine? ❑Y ❑ N Type:_____** **# Caffeinated beverages per day? _____**	**Is the patient Sexually active? ❑ Y ❑N** **Method of birth control?_____** **Does the patient drink alcohol? ❑Y ❑N** **Does the patient use tobacco ❑Y ❑N Type: _____** **Other substances? ❑Y ❑N Drug(s)/frequency of use?_____**

FOR FEMALES

Age at first period?	**Could you be pregnant now? ❑Y ❑N**
Date of your LAST period?	

Is there anything of a sensitive nature you would like to discuss with your physician? ❑Y ❑N

ADDITIONAL INFORMATION

Please use this space to complete any of the above questions or provide other relevant information.

Patient Signature or Patient's Legal Representative **Date**

Print **If not the patient, state you relationship to the patient or describe your authority to act on behalf of the patient.**