CHART #

Pediatric Health History Form – Initial Visit

Child's Name ______________________ Date of Birth ______________ Age ____________

Your Name ______________________ Relationship to Child ______________________

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? ______________

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications ______________

Delivery by ☐vaginal ☐c-section

Reason for c-section ______________

Complications ______________

Was your child premature ☐No ☐Yes, born at ______ weeks

Complications ______________

Apgar scores 1 minute ______ 5 minutes ______

Birth weight ______ Length ______

Other problems in the newborn period ______________

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease ______________
- ☐ Wheezing or bronchiolitis ______________
- ☐ Seasonal allergies or eczema ______________
- ☐ Food allergy ______________
- ☐ Recurrent ear infections ______________
- ☐ Pneumonia ______________
- ☐ Urinary tract infections ______________
- ☐ Genetic syndrome ______________
- ☐ Seizures ______________
- ☐ Anemia ______________
- ☐ Broken bone ______________
- ☐ Mental retardation or learning disability ______________
- ☐ Depression/anxiety ______________

Other chronic medical conditions ______________

Has your child ever been hospitalized ☐No ☐ Yes (explain)

Previous surgeries and dates ______________

Please list any specialist your child is currently seeing and reason:

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

Current medications and dose: ______________

Vitamins ______________

Herbal supplements ______________

Over-the-counter meds ______________

Development/Nutrition

At what age did your child: Sit alone ______

Walk alone ______ Say words ______

Toilet train(day) ______ 1st period (females) ______

Was your child breastfed ☐ No ☐Yes, how long? ______

Has your child had any unusual feeding/dietary problems? Explain.

Current milk intake: Type ______ Amount ______ oz/d

Created 12/2006

Social History

Who lives in the household with the child? ☐ Mom ☐ Dad ☐ Siblings (# ____) ☐ Grandparents ☐ Other ______

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) ______

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV ______ Computer ______ Video games ______

Child's school name ______________ Grade ______

Any concerns about school performance? ☐ No ☐ Yes, explain

Any concerns about peer or teacher relationships? ☐ No ☐ Yes

Sports/exercise: Type ______________

How often? ______ How long ______ min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
______	☐	☐	☐	☐

Please explain all positives. ______________

Review of Systems (*Check all that apply*)

Constitutional

- ☐ Fever, chills ☐ Fatigue
- ☐ Unexplained weight loss/gain
- ☐ Excessive thirst

Ear, Nose, and Throat

- ☐ Loud voice, hearing problem
- ☐ Mouth-breathing, snoring
- ☐ Ear pain
- ☐ Frequent runny nose

Respiratory

- ☐ Cough, short of breath
- ☐ Chest tightness, wheeze

Musculoskeletal

- ☐ Muscle pain, weakness
- ☐ Joint pain, swelling
- ☐ Bone pain

Other (eye,skin,blood)

- ☐ Blurry vision ☐ Squinting
- ☐ "Crossed" eyes ☐ Itchy eyes
- ☐ Rashes ☐ Abnormal moles
- ☐ Abnormal bruising, bleed

Gastrointestinal

- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation, blood in stool
- ☐ Abdominal pain

Cardiovascular

- ☐ Chest pain, palpitaions
- ☐ Tires easily with exertion
- ☐ Fainting

Genitourinary

- ☐ Frequent or painful urination
- ☐ Bedwetting, frequent accidents
- ☐ Vaginal or penile discharge

Neurologic

- ☐ Headaches ☐ Seizures
- ☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional

- ☐ Anxiety/stress ☐ Depression
- ☐ Sleep problem ☐ Anger concern
- ☐ Concerns with attention, impulsivity

Reviewed by ______________ ***date*** ______