PEDIATRIC HEALTH HISTORY

Name: _____ **Date of birth:** _____ M F
Date: _____ **Primary Physician:** _____

Allergies: _____

Medications: _____
_____

Injuries: _____

Hospitalizations: _____
_____

Prenatal History:

Any abnormalities noted during pregnancy? Please explain _____
_____

Type of delivery: _____ Gestational age at delivery: _____

Birth weight: _____ Birth length: _____

Infant health problems:

__ Birth defects __ Breathing problems __ Infection __Jaundice

__ Transfusion __ Prematurity __ Other _____

__ Breast feeding __ Formula feeding

Developmental milestones: ____Normal ___ Abnormal- Please explain: _____

Immunizations:

DTPa	Y N	Polio	Y N	Measles	Y N
Hepatitis B	Y N	Flu	Y N	Mumps	Y N
Chick Pox	Y N	Rubeila	Y N	PCV7	Y N

MEDICAL HISTORY:

Please check all that apply.

__ Asthma __Anemia __Bronchitis __Chicken Pox __Hepatitis __HIV __Measles __German Measles

__ Mumps __Prematurity __Pneumonia __ Sickle cell Disease __Whooping cough __Dizziness __Fainting

__Headaches __ Numbness __Excessive sweating __ Weight loss/gain __Chest pain __ Breathing problems

__Palpitations __Vision problems __Numbness __ Ear infections __Speech problems __Constipation __Diarrhea

__Excessive thirst __Excessive hunger __ Nausea __Vomiting __Frequent urination __Painful urination

__ Weakness __Mouth Breathing __ Persistent cough __ Strep Throat __ Tonsil infections __Sinusitis __Rash

__ Bruise easy __Broken bones __ Sport injuries __Other _____

Family History:

Please give the following information about your child's immediate family.

Father's age: _____ Mother's age: _____ Siblings ages: _____

Have any of your children died? Y N

Please indicate conditions that any of the blood relatives have had and the relationship to the child:

Condition	Relationship	Condition	Relationship
__ Alcoholism	_____	__ HIV/ AIDS	_____
__ Allergies	_____	__ Kidney disease	_____
__ Anemia	_____	__ Lung disease	_____
__ Arthritis	_____	__ Mental disorder	_____
__ Asthma	_____	__ Mental retardation	_____
__ Birth defects	_____	__ Muscle disorders	_____
__ Bone/joint disorders	_____	__ Rheumatic fever	_____
__ Seizures	_____	__ Cancer	_____
__ Diabetes	_____	__ Hypertension	_____
__ Genetic defects	_____	__ Stroke	_____
__ Heart disease	_____	__ Sudden death	_____
__ Hemophilia	_____	__ Thyroid disease	_____
__ TB	_____	__ Other	_____
__ High Cholesterol	_____		

To the best of my knowledge, the above information is complete and correct. I understand that reporting inaccurate or incomplete information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child has any change in health.

_____ _____

Signature of parent or guardian Date

_____ _____

Physician signature Date

Updates:

Has there been any change in your child's health since the last appointment? ___ Y ___ N

Please describe:

_____

_____

_____ _____

Parent/ Guardian signature Date

_____ _____

Physician Signature Date