

Pediatric Health History Form – Initial Visit

CHART #

Child's Name _____ Date of Birth _____ Age _____ Male _____ Female _____
 Mother's Name _____ Father's name _____
 Form filled out by _____ Date _____

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 _____

Previous pediatrician _____

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.

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step _____
☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Mother's occupation _____

Father's occupation _____

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

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

School's name _____ Grade _____

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

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____ Computer _____ Video games _____

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, bleeding

Gastrointestinal

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

Cardiovascular

☐ Chest pain, palpitations
☐ 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