

Pediatric Health History Form

0-13 Years

CHILD'S NAME _____ **AGE** _____

DATE OF BIRTH _____ Sex Assigned at Birth: ☐ Male ☐ Female

CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER _____

PRESENT HEALTH CONCERNS _____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS _____

MEDICINES/ VITAMINS _____

HERBS/ HOME REMEDIES _____

PREGNANCY & BIRTH

Is this child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other _____

Please indicate any medical problems during pregnancy: ☐ None ☐ Yes, specify: _____

Delivery by: ☐ Vaginal Birth ☐ C-Section : Why? _____

Did the child's birth occur in a : ☐ Hospital (& Name of Hospital): _____ ☐ Outside of Hospital

Birth Weight _____ Was your child premature? ☐ No ☐ Yes - Born at _____ weeks

Has your child ever been hospitalized? ☐ No ☐ Yes - please explain: _____

Has your child ever had surgery? ☐ No ☐ Yes - please explain: _____

Circumcision? ☐ No ☐ Yes Other Concerns/Comments: _____

NUTRITION & FEEDING

Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, specify _____

Milk Intake & Type: ☐ Cow Milk (☐ Non Fat ☐ 1% Fat ☐ 2% Fat ☐ Whole Milk) ☐ Alternative Milks
☐ Breast Milk ☐ Formula

How much milk does your child drink in a day? (Note 8 ounces are in 1 cup) _____

SLEEP

Hours Per Night _____ Naps (Number & Length) _____

Any Sleep Concerns? _____

DEVELOPMENT

Any Developmental Concerns? _____

Assigned Female at Birth Answer: Age at first menstrual period? _____

DENTAL HISTORY

Has your child been seen by a dentist? ☐ No ☐ Yes If so, how often? _____ Date of last visit: _____

IMMUNIZATIONS/INFECTIOUS DISEASES - Please bring your child's immunization records to your appointment.

Has your child had: ☐ Chickenpox ☐ Tuberculosis (TB)

EXPOSURES/HABITS

Any concerns about Lead Exposure (old home, plumbing, peeling paint)? ☐ No ☐ Yes

Do any household members smoke? Tobacco: ☐ No ☐ Yes Vape: ☐ No ☐ Yes

Time your child spends in front of a screen each day (TV, Tablet, Video Games): _____

FAMILY HISTORY - Please check any family history of the following (indicate who has/had the condition in the Notes area below).

- | | | |
|--|--|---|
| ☐ Alcoholism/Drug Abuse | ☐ Heart Disease or Stroke Before Age 60 | ☐ Seizures |
| ☐ Psychiatric Disorders | ☐ Thyroid Disease | ☐ Kidney Disease |
| ☐ High Blood Pressure | ☐ Bleeding/Clotting Problems | ☐ Birth Defects |
| ☐ Asthma / Eczema | ☐ Inherited/Genetic Diseases | |

Notes: _____

SOCIAL HISTORY

Who lives at home?

<u>Relationship</u>	<u>Age</u>	Are the Child's Parents:	Parent/ Guardian Occupations:
_____	_____	☐ Married	Parent/Guardian 1: _____
_____	_____	☐ Unmarried	_____
_____	_____	☐ Separated	_____
_____	_____	☐ Divorced	Parent/Guardian 2: _____
_____	_____	☐ Other	_____

Current Child Care Situation: ☐ Parents ☐ Other (specify who & hours per day) _____

Concerns about your child: ☐ Alcohol Use ☐ Tobacco ☐ Sexual Activity ☐ Aggressive Behavior

Is violence at home a concern? ☐ No ☐ Yes

Are there guns in the home? ☐ No ☐ Yes

SCHOOL HISTORY

Did/does your child attend school? ☐ No ☐ Yes - Current Grade _____ Name of School _____

Any concerns about school performance? _____

Any concerns about relationships with: Teachers ☐ No ☐ Yes _____

Students ☐ No ☐ Yes _____

If over 4 years old, does your child have a best friend? ☐ No ☐ Yes

Sports / Exercise Type: _____ How often? _____ How long (minutes)? _____

REVIEW OF ORGAN SYSTEMS - Please check/ select all symptoms that apply to your child:

Constitutional/ Endocrine

- ☐ Fevers ☐ Excessive Sweating ☐ Chills
☐ Unexplained Weight Loss or ☐ Gain

Eyes

- ☐ Squinting
☐ Crossing Eyes

Ears / Nose / Throat

- ☐ Unusually Loud Voice / Hard of Hearing
☐ Mouth Breathing or ☐ Snoring
☐ Frequent Runny Nose
☐ Problems with Teeth / Gums

Respiratory

- ☐ Cough / Wheeze

Muscular/ Skeletal

- ☐ Muscle/ Joint Pain

Gastrointestinal

- ☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation
☐ Blood in Bowel Movements

Cardiovascular

- ☐ Tires Easily with Exertion
☐ Shortness of Breath ☐ Fainting

Genitourinary

- ☐ Bedwetting
☐ Pain with Urination
☐ Discharge from Penis or ☐ Vagina

Neurological

- ☐ Headaches
☐ Weakness

Allergy

- ☐ Sneezing ☐ Itchy Eyes

Skin

- ☐ Rashes ☐ Unusual Moles

Psychiatric

- ☐ Anxiety/ Separation Anxiety
☐ School Refusal
☐ Sleep Concerns/ Nightmares
☐ Depression

- ☐ Recent Major Stressors

- ☐ Breath Holding

- ☐ Mood Changes

Blood /Lymph

- ☐ Unexplained Lumps

- ☐ Easy Bruising/ Bleeding

Developmental

- ☐ Speech Delay

- ☐ Learning Difficulty

Signature of Person Completing Form

Print Name

Date