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Chart #

Pediatric Health History Form – Initial Visit

Child's Name: _____
DOB: _____ 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 new born 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:
Walk alone _____ Sit Alone _____
Toilet train (day) _____ 1st period (female) _____
Was your child breastfed? ☐ No ☐ Yes, how long? _____
Has your child had any unusual feeding/dietary problems? Explain:

Current milk intake: Type _____ Amount _____ oz / cups

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, explain

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, 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
☐ Concern with attention, impulsivity

Reviewed by _____ *Date* _____