PEDIATRIC HEALTH HISTORY FORM

NAME OF PATIENT			Name of Person Completing Form
DATE			Relationship to Patient
SEX [ ]MALE [ ]FEMALE	RACE	SOCIAL SECURITY NUMBER	DATE OF BIRTH

Please list all people in the household:

	NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father				
Mother				
Other				
Other				
Other				
Other				

Have there been any recent major changes or stresses in the child's life? [ ]YES [ ]NO
If YES, please explain: _____

Does the child go to a baby-sitter, pre-school or day care regularly? [ ]YES [ ]NO

BIRTH HISTORY

Birth Weight _____ Length _____ Place _____

During the pregancy did the mother: (if YES, please explain) **Explanation**

- Have any medical problems? [ ]YES [ ]NO _____
- Smoke or drink? [ ]YES [ ]NO _____
- Use any medications? [ ]YES [ ]NO _____
- Use alcohol or other drugs? [ ]YES [ ]NO _____
- Have problems with labor/delivery [ ]YES [ ]NO _____

How long did the baby stay in the hospital after birth? _____

PAST MEDICAL HISTORY

Is the child's general health: [ ]Good [ ]Fair[ ]Poor (check one) **Explanation**

- Does the child have any allergies? [ ]YES [ ]NO _____
- Is the child taking any medications? [ ]YES [ ]NO _____

Please list any hospitalizations, operations, serious illnesses or accidents.

_____ Date: _____

_____ Date: _____

Has the child ever had any problems with the following? **Explanation**

- Eyes/Vision [ ]YES [ ]NO _____
- Feet [ ]YES [ ]NO _____
- Digestion/Nutrition [ ]YES [ ]NO _____
- Ears/Hearing [ ]YES [ ]NO _____
- Urine/Kidneys [ ]YES [ ]NO _____
- Joints [ ]YES [ ]NO _____
- Skin [ ]YES [ ]NO _____
- Lungs [ ]YES [ ]NO _____
- Teeth [ ]YES [ ]NO _____
- Heart [ ]YES [ ]NO _____
- Seizures [ ]YES [ ]NO _____
- Repeated Infections [ ]YES [ ]NO _____

Family History

Have any of the child's brothers or sisters died? [ ]YES [ ]NO
(If YES, please give age and cause) _____
Have any of the child's blood relatives had the following diseases: (If YES, please list family member)

		Family Member
Heart Disease	[ ]YES [ ]NO	
Tuberculosis	[ ]YES [ ]NO	
High Blood Pressure	[ ]YES [ ]NO	
Kidney Disease	[ ]YES [ ]NO	
Allergies/Asthma	[ ]YES [ ]NO	
Cancer	[ ]YES [ ]NO	
Diabetes	[ ]YES [ ]NO	
Mental/Emotional Problems	[ ]YES [ ]NO	
Sickle Cell	[ ]YES [ ]NO	
Seizures	[ ]YES [ ]NO	

Development

Do you have any concerns about the following? (If YES, please explain)

		Explanation
Development	[ ]YES [ ]NO	
Behavior	[ ]YES [ ]NO	
Eating Habits	[ ]YES [ ]NO	
Sleeping Habits	[ ]YES [ ]NO	
School Experience	[ ]YES [ ]NO	
Bathroom/Toilet Habits	[ ]YES [ ]NO	
Discipline	[ ]YES [ ]NO	
Other (explain)	[ ]YES [ ]NO	

IMMUNIZATIONS WILL BE COPIED ON IMMUNIZATION RECORD BY OFFICE STAFF

THIS SECTION IS FOR TEENAGERS AND IS TO BE COMPLETED BY THE TEEN

Do you:

Use Tobacco?	[ ]YES [ ]NO
Drink Beer or other Alcoholic Beverages?	[ ]YES [ ]NO
Use any kind of drugs?	[ ]YES [ ]NO

(For Females) How old were you when you had your first period? _____

Are you sexually active?	[ ]YES [ ]NO
If YES, do use birth control/protection?	[ ]YES [ ]NO
Have you ever been pregnant or fathered a child?	[ ]YES [ ]NO

Do you have any concerns about the following? (If YES, please explain)

Safety Issues	[ ]YES [ ]NO	
Substance Use (drugs, alcohol, tobacco)	[ ]YES [ ]NO	
Sexually Transmitted Diseases	[ ]YES [ ]NO	
Family Planning	[ ]YES [ ]NO	
Other (explain)	[ ]YES [ ]NO	

Reviewed By: _____ Date: _____