

PEDIATRIC HEALTH HISTORY FORM (one per child)

Patient Name _____ DOB: ____/____/____

Parent/Guardian Name _____ Date: ____/____/____ Relationship: _____

Present Health Concerns: _____

MEDICATIONS: Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc.

ALLERGIES: List all reactions to medicines, foods and other agents.

Medication Name	Dose	Frequency

Allergy	Reaction or Side Effect

* If the patient is taking 3 or more medications please bring them with you to each appointment.

PERSONAL MEDICAL HISTORY: Please indicate (circle) whether the patient has had any of the following medical problems.

Asthma/Wheezing
Anemia/ Bleeding Problem
Pneumonia
Diarrhea
Hearing Problems
Diabetes
Other _____

Heart Disease/Murmur
Ear Infections
Convulsions/Epilepsy
Constipation
Headache
Other _____

Vision Problems
Environmental Allergy
Bladder/Kidney Infections
Skin Problems
Developmental Delay
Other _____

HOSPITALIZATIONS/OUTPATIENT PROCEDURES: Please list all prior hospitalizations/serious illnesses and dates.

Reason for hospitalization	Date

IMMUNIZATIONS: Please attach a list or list immunization dates that the patient has received at other health care facilities.

Hepatitis A: _____ DTaP: _____ Polio: _____ Pevnar: _____ MMR: _____
 Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Menactra: _____
 HIB : _____ HPV : _____ MenQuadfi: _____ Other: _____

COMMUNICABLE DISEASES: Has your child ever had any of the following infectious disease(s)?

Chickenpox Measles Mumps Meningitis
 Covid 19 RSV Rubella Tuberculosis (TB)

PREGNANCY & BIRTH:

Is the child yours by: Birth Adoption Stepchild Other: _____

Method of Delivery: Vaginal Caesarean

Hospital of Birth: _____ Country of Birth: _____

Were there any medical problems during pregnancy? Yes No

If yes, please explain: _____

Maternal smoking Alcohol Drugs Medications

Were there any problems during labor and delivery? Yes No

If yes, please explain: _____

After the baby's birth, were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), infection etc? Yes No

If yes, please explain: _____

Birth weight/length: _____ lbs _____ oz

Was your child born prematurely? Yes No If yes how early? _____

SLEEP:

Hours per night: _____ How many naps per day: _____

Does your child have any sleep problems? Yes No

If yes, please explain: _____

NUTRITION & FEEDING:

Type of feeding as newborn/infancy: Formula Breastfed If breastfed, for how long? _____

Has your child had any feeding/dietary problems or restrictions? Yes No

If yes, please explain: _____

Milk intake now: Soy Milk Rice Milk Cow's Milk (_____%) Other, please specify: _____

Ounces per day: _____

Has your child seen a dentist? Yes No If yes, date the last visit: _____

What is the water source at the house? City Well

Does your child use a bottle? Yes No Pacifier? Yes No

DEVELOPMENT (May skip this section if child is older than age 12):

At what age did your child: Sit Alone _____ Walk Alone _____ Say Words _____ Toilet Trained (Daytime) _____ Dry at Night _____

Any concerns about growth or progress with rolling over, walking, riding a tricycle, dressing themselves, feeding themselves, or potty training?
Yes No

If yes, please explain: _____

Any concerns about language or speech development? Yes No

If yes, please explain: _____

In the car, does your child use: Infant seat Booster Seat Seatbelt Only

Does your child wear a helmet while riding a bike? Yes No

Do you have concerns about your child's behavior at home or in groups with other children? Yes No

If yes, please explain: _____

For Female Patients Only: Age at first menstrual period: _____

