

PEDIATRIC HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Date:

Name:

(Last, First, M.I.)

M

F

DOB

Other healthcare practitioners:

Name:

Type of practice:

Phone number:

Please list your current health concerns for your child in order of their importance to you

Concern:

Date of onset:

1.

2.

3.

Yes No Traumas, Car Accidents, Injuries?

Surgeries and Hospitalizations:

Date

Reason

Hospital

Has your child ever had a blood transfusion? Yes No

BIRTH HISTORY

Prenatal history:

Yes No Did mother have any problems or illness during pregnancy?

If so, describe:

Birth History:

Vaginal Cesarean Section Forceps Vacuum Trauma?

On time Before 37 weeks of pregnancy After 42 weeks of pregnancy

Any newborn problems? Jaundice Hospitalization Other, describe

Illness:

Has your child had antibiotics? If so, how many times?

DIET

Describe your baby's diet

If your child is eating solids, describe what she/he has eaten in the last 24 hours....

Breastmilk only

Formula

Mixed

Time:	Food eaten- describe ingredients	Amount

PAST MEDICAL HISTORY

Does your child have, or has she/he had:

<input type="checkbox"/> Yes <input type="checkbox"/> No Chicken pox	<input type="checkbox"/> Yes <input type="checkbox"/> No Constipation requiring a doctor visit
<input type="checkbox"/> Yes <input type="checkbox"/> No Ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No Bladder or kidney infection
<input type="checkbox"/> Yes <input type="checkbox"/> No Problems with ears or hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No Bed-wetting (if over 5 years old)
<input type="checkbox"/> Yes <input type="checkbox"/> No Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No (girls) Started menstruating?
<input type="checkbox"/> Yes <input type="checkbox"/> No Problems with eyes or vision	<input type="checkbox"/> Yes <input type="checkbox"/> No (girls) Any problems with periods?
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma, bronchitis, croup or pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No Chronic or recurrent skin problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart problems or murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent headaches
<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No Seizures or other neurologic problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes or thyroid problems

FAMILY HEALTH HISTORY

Is your child adopted? Yes No
Have any family members had the following? If so, note relationship to child

<input type="checkbox"/> Yes <input type="checkbox"/> No Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Allergies/ Hayfever	<input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes before age 50
<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No Bed-wetting after age 10
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease before age 50	<input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy or convulsions
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure before age 50	<input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol or drug abuse
<input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No Developmental disability
<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Mental illness

SOCIAL HISTORY AND DEVELOPMENT

Home Environment:

How many children in your home?	Child's birth order (3 rd of 4 kids...)
What adults live with your child?	Has your child had any traumas or losses?

School Age Children:

<input type="checkbox"/> Yes <input type="checkbox"/> No Has he/she ever been "held back" or had to repeat a grade?
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about your child's attention span?
<input type="checkbox"/> Yes <input type="checkbox"/> No Does your child like school?
<input type="checkbox"/> Yes <input type="checkbox"/> No Any concerns about your child's behavior in school?
<input type="checkbox"/> Yes <input type="checkbox"/> No Any concerns about how he/she is doing academically?

What is your plan for vaccination? CDC standard schedule Alternative Schedule No vaccination

