PEDIATRIC HEALTH HISTORY FORM

(Birth - 5 years)

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Patient's name ______________________________ Date ______________

Age ________ Date of Birth ____________ Gender: female ______ male ____________

Mother's name ______________________________ Father's name ______________________________

Address ____

Phone #'s (home) ______________________________(cell) ______________________________

Email addresses____

Is there anyone we can thank for referring you here? ______________________________

Name of Doctor's office/Clinic where your child's former health records are kept:

____

Reason(s) for your visit today: ______________________________

____

____

MEDICATIONS	Now	Past		Now	Past
Aspirin	______	______	Antibiotics	______	______
Tylenol	______	______	Anti-histamine	______	______
Decongestants	______	______	Other	______	______
Ibuprofen	______	______	Allergies to medicines ______________________________		

MEDICAL HISTORY

______ Chicken pox	______ Scarlet fever	Tonsillitis, approx. no. __________
______ Measles	______ Pneumonia	Ear infections, no. ____________________
______ Mumps	______ Frequent colds	Other (please list) ______________________________
______ Rubella	______ Rheumatic fever	Allergic reactions______________________________

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram			
Psychological evaluation			
Hearing			
Speech/Language			

Injuries/Surgeries/Hospitalizations (please list): ____

____

____

IMMUNIZATIONS

What immunizations has your child had or is he/she current on his/her vaccination schedule?

____

Any adverse reactions to immunizations? Y N What were the reactions?

____

FAMILY HISTORY

______ Heart disease ______ Diabetes ______ Hypertension
______ Cancer ______ Allergies ______ Mental illness

PRENATAL HISTORY

Previous pregnancies by birth mother; miscarriages or complications? ______________________________

Mother's age at child's birth? __________

Mother's health during pregnancy?

______ Bleeding ______ Physical or emotional trauma
______ Nausea ______ Cigarettes, alcohol, drug consumption
______ Illnesses ______ Medications
______ Hypertension ______ Thyroid problems ______ Diabetes

BIRTH HISTORY

Term: Full _______ Pre-mature ________ Late_________ Weight at birth____________________

Length of labor ______________________ Complications? ______________________________

Did your child have any of the following problems shortly after birth?

________ Birth defects ________ Birth injuries ________ "Blue baby" syndrome
________ Cerebral palsy ________ Seizures ________ Jaundice
________ Colic ________ Fever ________ Rashes

Other (explain) ____

____

____

Child's sleep patterns (first year) ____

Food intolerance (if any) ____

Feeding: Breast-fed? Y or N How long? ____________ Formula? Y or N What type? ______________

Age began solid foods _____ Which foods, first? ____

Age began: Sitting ________ Crawling_________ Walking________ Talking__________

SYMPTOMS (mark Y if current, P for past symptoms)

_______ Hives	_______ Burning of urine	_______ Blood in urine
_______ Eczema	_______ Frequent urination	_______ Cries easily
_______ Bleeding gums	_______ Heart murmur	_______ Nervous
_______ Nose bleeds	_______ Vomiting spells	_______ Sleep problems
_______ Acne	_______ Anemia	_______ Night sweats
_______ High fevers	_______ Stomachaches	_______ Sensitive to light
_______ Chronic rash	_______ Jaundice	_______ Body/breath odor
_______ Hearing loss	_______ Easy bruising	_______ Motion/car sickness
_______ Diarrhea	_______ Flat feet	_______ No appetite
_______ Sore throats	_______ Constipation	_______ Nightmares
_______ Headaches	_______ Gas	_______ Canker sores
_______ Frequent colds	_______ Bleeding tendency	_______ Unusual fears
_______ Wheezing	_______ Joint pains	_______ Excessive fatigue
_______ Cough	_______ Dizzy spells	_______ Hair loss

DIET

Please describe your child's typical, daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Is there anything else you would like to add?

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Welcome! We look forward to working with you and your child.