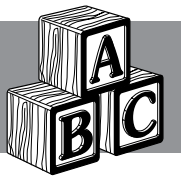
We're Patient People



PEDIATRIC HEALTH HISTORY

Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can.

Date: SS # Acct. #

Child's full legal name Date of Birth ☐ Male ☐ Female

Place of birth (Hospital) City & State

Mother's full name D.O.B. Occupation

Father's full name D.O.B. Occupation

Home Address

City State Zip Home Phone

Parents: ☐ Married ☐ Single ☐ Divorced Religious preference (optional)

Other parent address (if different from above)

City State Zip Phone

Child's School Grade

Previous physician City/State Phone

ALLERGIES

Substance	Reaction

MEDICATIONS

Medication Name	Dosage

FAMILY HISTORY

Please give the following information about your child's immediate family:

	Age	General Health	Sibling Name	Age	General Health	
Father						☐M ☐F
Mother						☐M ☐F
Have any of your children died? ☐ No ☐ Yes						☐M ☐F
						☐M ☐F

Please check conditions that any of the child's blood relatives (including parents and siblings) have had and the relationship to the child:

Condition	Relationship	Condition	Relationship
☐ Alcoholism		☐ HIV/AIDS	
☐ Allergies		☐ Kidney disease	
☐ Anemia		☐ Lung disease	
☐ Arthritis		☐ Mental disease/disorder	
☐ Asthma/emphysema		☐ Mental retardation	
☐ Birth defects		☐ Muscle disorders	
☐ Bone/joint disorders		☐ Rheumatic fever	
☐ Cancer		☐ Seizures/convulsions	
☐ Diabetes		☐ Sickle cell anemia	
☐ Epilepsy		☐ Skin disease	
☐ Eye or ear disorders/Hearing loss/Blindness		☐ Stroke	
☐ Genetic defects		☐ Thyroid disease	
☐ Heart disease		☐ Tuberculosis	
☐ Hemophilia		☐ Venereal disease	
☐ High blood pressure		☐ Other	

PRE-NATAL AND INFANT HEALTH HISTORY

Place of birth Hospital Obstetrician

During the pregnancy which conditions did you have? Please check all that apply:

- ☐ Alcohol use
- ☐ Anemia
- ☐ Diabetes
- ☐ Drug use, non-prescription (Please list)
- ☐ Drug use, prescription (Please list)
- ☐ Drug use, controlled or illegal (Please list)
- ☐ Edema (Swelling)
- ☐ Exposure to chemical or radiation
- ☐ Fever
- ☐ German measles
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Protein in urine
- ☐ Tobacco use
- ☐ Urinary tract infection
- ☐ Venereal disease
- ☐ Other illnesses or infections (Please list below)

Mother's age at birth

DELIVERY Please check all that apply:

☐ Full Term ☐ Premature ☐ Post Term ☐ Normal ☐ Induced ☐ Prolonged ☐ Breech ☐ C-Section

Please describe

INFANT HEALTH

Birthweight Length

Discharge weight Age when discharged

INFANT HEALTH PROBLEMS Please check and describe.

- ☐ Birth Defects
- ☐ Breathing problems
- ☐ Infection
- ☐ Jaundice
- ☐ Transfusion
- ☐ Other

FEEDING

☐ Breast fed ☐ Formula fed

Circumcision ☐ Yes ☐ No

DEVELOPMENTAL Please note age at which your child:

Lifted head	Wk.
Rolled over	Mo.
Cooed/Laughed	Mo.
Sat up	Mo.
Stood up	Mo.
Walked	Mo.
Finger fed	Mo.
Drank from cup	Mo.
Spoon fed	Mo.
First word	Mo.
Toilet trained	Mo.
Dressed self	Mo.

IMMUNIZATIONS

PLEASE PROVIDE US WITH PROOF OF IMMUNIZATION

Has your child had any unusual reactions to any vaccines? ☐ Yes ☐ No

Please describe:

Do you have any other concerns about the immunization(s)?

ADDITIONAL INFORMATION

MEDICAL HISTORY

Please check if child has ever had any of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Measles (10-day)
- ☐ Measles, Rubella (3-day)
- ☐ Mumps
- ☐ Rheumatic fever
- ☐ Pneumonia
- ☐ Whopping cough
- ☐ Other

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Mood swings
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweating
- ☐ Tiredness
- ☐ Weight loss/gain

CARDIOVASCULAR

- ☐ Breathing problems
- ☐ Chest pain
- ☐ Irregular heart beat

EYES

- ☐ Crossed or wandering eyes
- ☐ Eye irritation
- ☐ Headaches
- ☐ Vision problems

HEARING / SPEECH

- ☐ Difficulty hearing
- ☐ Earache
- ☐ Ear infections
- ☐ Hoarseness
- ☐ Speech problems

DENTAL

- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Sensitivity to hot / cold
- ☐ Thumb-sucking
- ☐ Last dental check-up

  Date
- ☐ Brush, how often?
- ☐ Floss, how often?

MENTAL HEALTH

- ☐ ADD
- ☐ ADHD
- ☐ Anorexia
- ☐ Autism
- ☐ Dev. Delay
- ☐ Depression
- ☐ Speech Tx
- ☐ Occupational Tx

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloody or dark stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach aches
- ☐ Vomiting
- ☐ Worms

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Diaper rash, persistent
- ☐ Discharge from vagina or penis
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Unusual urine odor

MUSCLE / JOINT / BONE

- ☐ Broken bones or sprains
- ☐ Coordination problems
- ☐ Posture problems

- ☐ Pain, weakness, swelling in:
  - ☐ Arms ☐ Hips
  - ☐ Back ☐ Legs
  - ☐ Feet ☐ Neck
  - ☐ Hands ☐ Shoulders

NOSE / THROAT / CHEST

- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Mouth-breathing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sore throats
- ☐ Strep throat
- ☐ Tonsil infections
- ☐ Wheezing

SKIN

- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

HOSPITALIZATIONS

Reason	Date	Hospital, City, State

INJURIES

Serious Injuries/Illnesses	Date	Outcomes

Has your child ever had a blood transfusion? ☐ Yes ☐ No

DIETARY ASSESSMENT

How often does your child eat the following:

	3 Times Daily	Daily	Weekly	Monthly
Beans, peas	☐	☐	☐	☐
Breads, cereals, grains	☐	☐	☐	☐
Candy	☐	☐	☐	☐
Dairy products	☐	☐	☐	☐
Eggs	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Meats	☐	☐	☐	☐
Poultry, fish	☐	☐	☐	☐
Sodas	☐	☐	☐	☐
Vegetables, green	☐	☐	☐	☐
Vegetables, yellow	☐	☐	☐	☐

What vitamin supplements does your child take? How often?

Is there fluoride in your water? ☐ Yes ☐ No

Appetite: ☐ Good ☐ Poor ☐ Excellent ☐ Picky

Food Allergies

Other / Explain

Dietary Preference: ☐ All food groups ☐ Vegetarian ☐ Other

EDUCATION AND SOCIAL HISTORY

Please explain any problems or concerns you have about your child in any of the following areas:

Appearance/Weight/Height

Behavior

Friends

Grades/learning ability

Sexuality

How many hours per day does your child watch television or play video games? Get exercise?

Do you suspect that your child is involved with: ☐ Drugs ☐ Alcohol ☐ Tobacco

Have you noticed any of the following warning signs of drug abuse:

Angry behavior	☐ No	☐ Yes	Depression	☐ No	☐ Yes
Changes in appearance	☐ No	☐ Yes	Signs of drugs in the house	☐ No	☐ Yes
Changes in attitude	☐ No	☐ Yes	Skipping school	☐ No	☐ Yes
Changes in friendships	☐ No	☐ Yes	Withdrawal from friends or family	☐ No	☐ Yes

CHILD SAFETY INVENTORY

Adequate number of working smoke alarms?	☐ Yes	☐ No	Safety plugs in unused wall sockets?	☐ Yes	☐ No
Does child use car seat/seat belt?	☐ Yes	☐ No	Safety gate for stairs?	☐ Yes	☐ No
Medicines, cleaning supplies, chemicals out of reach?	☐ Yes	☐ No	Known dangers of peeling paint, mice/rats in the home?	☐ Yes	☐ No
Ipecac Syrup in the home?	☐ Yes	☐ No	Does child know how to swim?	☐ Yes	☐ No
Know poison control phone number?	☐ Yes	☐ No	Are guns in the home in locked storage?	☐ Yes	☐ No
Water heater set below 120° F?	☐ Yes	☐ No	Does child use bicycle helmet?	☐ Yes	☐ No

FAMILY HOUSEHOLD

Child lives at home with ☐ Parents ☐ Mother ☐ Father ☐ G. Parents ☐ Other

Smoking inside home ☐ Yes ☐ No

Pet(s) inside home ☐ Yes Type ☐ No

Other

PARENT CONCERNS Please explain any other concerns or questions you have about your child.

This is to certify that I have answered the questions on this form to the best of my knowledge. I understand that to provide incorrect information about my child's health and symptoms could place my child's health at risk.

Parent/Guardian Signature Date

DR. COMMENTS

Physician Signature Date