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Pediatric Health History

Patient's Name:_____ Date:_____
Age:_____ Date of Birth:_____ Time of Birth:_____
Place of Birth:_____ Gender: Female / Male
Parent/Guardian's Name:_____
Insurance Plan:_____ Subscriber ID:_____
Subscriber Group #:_____ Subscriber Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone (home):_____ Cell/Work:_____
Emergency Contact:_____ Phone:_____
Parent's e-mail:_____
How did you hear about my clinic?_____
Has any other family member been a patient of ours?_____
Name of office where your child's records are kept:_____
_____
Reason for visit:_____
_____

MEDICATIONS

NOW	PAST		NOW	PAST	
___	___	Aspirin	___	___	Decongestants
___	___	Tylenol	___	___	Anti-histamine
___	___	Antibiotics	___	___	Other:_____
___	___	Ibuprofen	Allergies:_____		

MEDICAL HISTORY

___ Chicken pox ___ Scarlet Fever ___ Tonsillitis, approx # of times:_____
___ Measles ___ Pneumonia ___ Ear Infections, approx # of times:____
___ Mumps ___ Frequent colds ___ Strep Throat, approx # of times:_____
___ Rubella ___ Rheumatic fever ___ Eczema ___ Asthma
Other:_____

Has your child had any of the following?	WHEN	WHERE	RESULTS
Electroencephalogram (EEG):			
Psychological Evaluation:			
Hearing Test:			
Speech/Language Test:			

Injuries/Surgeries/Hospitalizations (please list): _____
_____

IMMUNIZATIONS

___ MMR ___ DPT ___ Chicken Pox ___ Hepatitis B
___ Measles ___ Diphtheria ___ Small Pox Others: _____
___ Mumps ___ Tetanus ___ H. influenza Adverse Reactions?: Y / N
___ Rubella ___ Polio ___ Flu Explain: _____

FAMILY HISTORY

___ Heart Disease ___ Diabetes ___ Birth Defects ___ Cancer
___ Hypertension ___ Arthritis ___ Tuberculosis ___ Allergies
___ Asthma ___ Mental Illness ___ Osteoporosis Other: _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages or complications?: _____
_____
Mother's age at child's birth: _____
Mother's health during pregnancy:

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

BIRTH HISTORY:

Term: ____ Full ___ Premature ___ Late Weight at birth: _____
Length of Labor: _____ Complications: _____

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

___ Rashes ___ Birth Injuries ___ Blue baby
___ Jaundice ___ Seizures ___ Cerebral palsy
___ Colic ___ Fever ___ Birth defects
___ Other: _____

Child's sleep patterns: _____
Food Intolerances: _____
Breast fed?: Y / N How long?: _____ Formula: Y / N Type: _____
Age began solids: _____ Which foods?: _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

___ Hives ___ Burning urine ___ Bloody urine ___ Eczema
___ Cries easily ___ Bleeding gums ___ Heart murmur ___ Nervous
___ Nose bleeds ___ Vomiting spells ___ Sleep problems ___ Asthma
___ Acne ___ Anemia ___ Night sweats ___ High fevers
___ Jaundice ___ Sensitive to light ___ Chronic rash ___ Stomach aches
___ Diarrhea ___ Hearing loss ___ Easy bruising ___ Sore throats
___ Flat feet ___ No appetite ___ Body/breath odor ___ Constipation
___ Nightmares ___ Headaches ___ Bleeding ___ Unusual fears
___ Wheezing ___ Joint pains ___ Excessive fatigue ___ Cough
___ Dizzy spells ___ Hair loss ___ Frequent urination ___ Allergies

DIET Please describe your child's typical daily diet, including snacks and beverages:

_____
_____