Adventist Health
Physicians Network

Pediatric Health History Form

CHILD'S NAME: **DATE OF BIRTH:**

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

PRESENT HEALTH CONCERNS:

CURRENT MEDICATIONSNITAMINS:

ALLERGI ES TO MEDICATIONS/FOODS/ VACCINES **REACTION:**

PREGNANCY & BIRTH (Please fill out if your child is <6 years old):

Birth Hospital: Obstetrician:

Is the child yours by: Birth Adoption Stepchild Other:

Please indicate any medical problems during pregnancy: None Specify:

Delivery by: Vaginal birth Caesarean If Caesarean, why?

Birth weight: Length of Hospital Stay:

If premature, how early?

Please indicate any medical problems during the baby's newborn period: None Specify:

NUTRITION & FEEDING

Do you have any concerns about your child's weight or diet? No Yes

If yes, specify:

DEVELOPMENT: Please describe any concerns you have regarding your child's development.

DENTAL HISTORY: Has child been seen by a dentist in the last year? No Yes

EXPOSURES:

Do any household members smoke around the child? No Yes

PAST MEDICAL HISTORY:

Hospitalizations/Operations (with dates):

Please describe any major medical problems and their dates.

FAMILY HISTORY

Please check off medical conditions if present or check here is entire family is healthy

	Father	Mother	Maternal Grand-Father	Maternal Grand-Mother	Paternal Grand-Father	Paternal Grand-Mother	Sibling Name:	Sibling Name:	Sibling Name:
Allergies									
Anemia									
Asthma									
Autism									
Cancer Type:									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Migraines									
Stroke									
Sudden death (<30 years old)									
Thyroid Disease									
Other:									
Other:									

SOCIAL HISTORY:

Who lives at home? (Names and ages)

Are the child's parents Married Unmarried Separated Divorced

Mother's Occupation: Father's Occupation:

Concerns about your child: Alcohol use Tobacco Sexual activity

Is violence at home a concern? No Yes

Are there guns in the home? No Yes Decline to answer

SCHOOL HISTORY:

Current grade in school: Not in school

Any concerns about school performance?

Sports/exercise: Type How often? How long (minutes)?