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

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PAST MEDICAL HISTORY

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

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

☐ Yes ☐ No	Deafness	☐ Yes ☐ No	Liver disease
☐ Yes ☐ No	Hayfever/ Eczema/ Asthma	☐ Yes ☐ No	Kidney disease
☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Diabetes before age 50
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Bed-wetting after age 10
☐ Yes ☐ No	Bleeding disorder	☐ Yes ☐ No	Epilepsy or convulsions
☐ Yes ☐ No	Heart Disease before age 50	☐ Yes ☐ No	Alcohol or drug abuse
☐ Yes ☐ No	High Blood Pressure before age 50	☐ Yes ☐ No	Developmental disability
☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Mental illness

SOCIAL HISTORY AND DEVELOPMENT

Home Environment:

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

School Age Children:

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

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

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