NEW PEDIATRIC PATIENT HEALTH HISTORY FORM

Child's Name:		**Date:**
Primary Care Provider:	Age	DOB

Allergies/Reactions: ***

Please list any present health concerns:	**List any medications your child takes daily.** ***	**Herbs/home remedies used?**

PREGNANCY AND BIRTH ***

1.	Is your child: ☐ Birthed ☐ Adopted ☐ Stepchild Other:
2.	Any medical problems during pregnancy?: ☐ No ☐ Yes, Specify:
3.	Delivered by: ☐ Vaginal Birth ☐ Caesarean, why:
4.	Birth Weight: lbs: oz Birth Length inches
5.	Please indicate any medical problems during the baby's newborn period: ☐ None ☐ Premature weeks:

Other problems:

NUTRITION AND FEEDING

1.	Was your child breastfed? ☐ No ☐ Yes, how long?
2.	Any unusual feeding/dietary concerns? ☐ No ☐ Yes, specify:
3.	Milk intake currently: ☐ Cow milk (non-fat, 1% fat, 2% fat, whole milk) ☐ Soy milk ☐ Rice milk

Average ounces per day (Note: 8 ounces are in 1 cup):

SLEEP

Hours of sleep per night: Naps (number and length):

Any sleep problems: ☐ No ☐ Yes, explain:

DEVELOPMENT

What age did your child: Sit alone: Walk alone: Say words: Toilet train:

If applicable: Age at first menstrual cycle:

DENTAL HISTORY

Has child been seen by a dentist? ☐ No ☐ Yes, how often: Last visit date:

IMMUNIZATIONS/INFECTIOUS DISEASES: ***Please bring your child's immunization records to your appointment.***

Has your child had chickenpox ☐ No ☐ Yes

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates: ***

FAMILY HISTORY Please check off any family history of the following (indicate who has/had the condition)

☐ Alcoholism/Drug Abuse	☐ Heart Disease or Stroke before 60	☐ Inherited/Genetic Diseases
☐ High Blood Pressure	☐ Thyroid Disease	☐ Psychiatric Disorders
☐ Asthma/Hay fever/Eczema	☐ Bleeding/Clotting Problems	☐ Seizures
☐ Kidney Disease	☐ Birth Defects	☐ Other

Social History* **	Birthplace:	Current (or upcoming) grade:	
Child lives with:			
Name:	Age:	Relationship:	Education Level:
Name:	Age:	Relationship:	Education Level:
Name:	Age:	Relationship:	Education Level:
Name:	Age:	Relationship:	Education Level:
Name:	Age:	Relationship:	Education Level:

Are the child's parents: ☐ Married ☐ Unmarried ☐ Separate ☐ Divorced, when?

Parent's Occupation: Mother: Father:

Child care situation ☐ Parents ☐ Daycare ☐ Other Hours per day

Concerns about your child: ☐ Alcohol use ☐ Tobacc ☐ Sexual activity ☐ Aggressive behavior

Is violence at home a concern: ☐ No ☐ Yes	Are there guns in the home? *** ☐ No ☐ Yes
EXPOSURES/HABITS: ***	Any concerns about lead exposure (old home/plumbing/peeling paint)? ☐ No ☐ Yes

Do any household members smoke? *** ☐ No ☐ Yes

TV hours per day: Computer hours per day: Video games hours per day:

School History	Did/does your child attend preschool? ☐ No ☐ Yes Current Grade:
Name of school:	Any concerns about school performance?

Any concerns about relationships with: Teachers ☐ No ☐ Yes, explain:
Students ☐ No ☐ Yes, explain:

If over 4 years old, does your child have a best friend? ☐ No ☐ Yes

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

REVIEW OF ORGAN SYSTEMS: PLEASE CIRCLE ANY THAT ARE RELEVENT

Constitutional/Endocrine	Gastrointestinal	Allergy	
*Fevers/chills/excessive *Sweating *Unexplained weight loss/gain	*Nausea/vomiting/diarrhea *Constipation *Blood in bowel movement	*Hay fever *Itchy eyes	
Eyes	Cardiovascular	Skin	Muscular
*Squinting/"crossed" *Eyes/asymmetric gaze	*Tires easily with exertion *Shortness of breath *Fainting	*Rashes *Unusual moles	* Joint Pain
Ears/Nose/Throat	Genitourinary	Psychiatric	
*Unusually loud voice/hard of hearing *Mouth breathing/snoring *Bad breath *Frequent runny nose *Problems with teeth/gums	*Bedwetting *Pain with urination *Discharge: penis or vagina	*Speech problems *Anxiety/Stress *Problems with sleep/nightmares *Depression *Nail biting/thumb sucking *Bad temper/breath holding/jealousy	
Respiratory	Neurological	Blood/Lymph	
*Cough/wheeze	*Headaches *Weakness *Clumsiness	*Unexplained lumps *Easy bruising/bleeding	