



Pediatric Health History (Confidential)

Child's Name _____ Today's Date _____
 Age _____ Birthdate: _____ Date of last physician examination _____
 What is your reason for today's visit? _____ Name of Pediatrician: _____

SYMPTOMS Check () symptoms you currently have or have had in the past.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	Mother's Pregnancy History
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Delivery Complication: Yes ___ No ___
<input type="checkbox"/> Depression	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	Female Patients
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Ear Infections	
<input type="checkbox"/> Fainting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Frequent Runny Nose	Menstrual period _____
<input type="checkbox"/> Fever	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Hard of hearing	Pap Smear _____
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Nosebleeds	Concerns About Your Child
<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea	<input type="checkbox"/> Persistent cough	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Unusual loud voice	<input type="checkbox"/> Aggressive Behavior
<input type="checkbox"/> Loss/Gain of weight	Psychiatric/Emotional	SKIN	Yes ___ No ___
<input type="checkbox"/> Muscle/Joint Pain	<input type="checkbox"/> Nail Biting	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Sweats	<input type="checkbox"/> Thumb sucking	<input type="checkbox"/> Hives	Yes ___ No ___
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Bad Temper	<input type="checkbox"/> Itching	<input type="checkbox"/> How Much?
	<input type="checkbox"/> Breath Holding	<input type="checkbox"/> Moles	
	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Rash	

CONDITIONS Check () conditions you have or have had in the past.

<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Heart Disease/Murmur	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Caffeine
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stomach/Bowel Problems	Yes ___ No ___
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Thyroid Problems	How Much?
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Computer Usage
<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Ulcers	Yes ___ No ___
<input type="checkbox"/> Autism	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Urinary Problems	How Much?
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Drugs
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Measles		Yes ___ No ___
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Migraine/Headaches		How Much?
<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis		<input type="checkbox"/> Exercise
Type: _____	<input type="checkbox"/> Mumps		Yes ___ No ___
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pneumonia		How Often? _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sexually Transmitted Disease		<input type="checkbox"/> Television
<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Scoliosis		Yes ___ No ___
			How Much?
			<input type="checkbox"/> Tobacco
			Yes ___ No ___
			How Much?
			<input type="checkbox"/> Sexually Active
			Yes ___ No ___
			<input type="checkbox"/> Video Games
			Yes ___ No ___
			How Much?

Are immunizations up to date? Yes ___ No ___

Please bring your child immunization records to your appointment.

At what age did your child: Sit Alone _____ Walk Alone _____
 Say Words _____ Toilet train _____
 Girls Only: Had first menstrual period _____

Is this child yours by: Adoption Birth
 Stepchild Other _____

Do any household members smoke? Yes ___ No ___

Has child been seen by dentist? Yes ___ No ___



Patient Name: _____

DOB: _____

Pediatric Health History (Cont.)

Current Medication List:		ALLERGIES to medications or substances
		Latex?
Pharmacy Name:		Pharmacy Phone Number:

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No
 If Yes, give approximate dates: _____

SERIOUS ILLNESS, INJURIES	DATE	OUTCOME

FAMILY HISTORY

Fill in health information about your family			
Who?	What Condition?	Age Of Onset	Cause of Death

Check if your blood relatives had any of the following:
Disease
Arthritis, Gout
Asthma, Hay Fever
Cancer
Chemical Dependency
Diabetes
Heart Disease, Strokes
High Blood Pressure
Kidney Disease
Tuberculosis
Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Reviewed By