Pediatric Health History

Patient Name: ______________________________ Date of Birth: ______________

Today's Date: ______________________ Doctor you are seeing today: ______________________

How did you hear about our practice? ______________________________

Height: ______________ Weight: ______________ Age: ______________ Sex: ☐ M ☐ F

Blood Pressure: ______________ Temp: ______________ Pulse: ______________

What is the primary reason for your child's visit with the doctor today?______________________________

____

Does your child have a:

Latex Allergy ☐ Yes ☐ No

Drug Allergy ☐ Yes ☐ No

If yes, please list medications and reactions: ______________________________

____

Medications

Please list any medications that your child takes on a regular basis. Include medication name, dose, and frequency.

____

____

Past Medical History

Does your child have any medical problems? ☐ Yes ☐ No

Please list: ______________________________

____

____

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Has your child ever had cancer? ☐ Yes ☐ No

If so, what type? ______________________________

Past Surgical History

Has your child ever had surgery? ☐ Yes ☐ No

Please list type and approximate date: ______________________________

____

Social History for Children:
Who is the primary caregiver of your child (mother, father, grandparent, etc.)?

____

Does your child attend daycare? ☐ Yes ☐ No
Does anyone smoke around your child? ☐ Yes ☐ No
Have immunizations been updated? ☐ Yes ☐ No
When? ____
Does your child have siblings? ☐ Yes ☐ No
Age(s) ____

Health problems of siblings: ____

____

____

Family History: Any family history of the following? If yes, please list relation to the child:

Heart Disease	☐ Yes	☐ No	________
Arthritis	☐ Yes	☐ No	________
Cancer	☐ Yes	☐ No	________
Diabetes	☐ Yes	☐ No	________
Bleeding tendencies	☐ Yes	☐ No	________
Other ________			________

Review of Systems: Does the child currently have any of the following symptoms?

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Lethargy	☐ Yes	☐ No
Weight gain/loss	☐ Yes	☐ No

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No

Neurological

Dizzy spells	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No

Hematological/Lymphatic

Blood clotting problem	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Swollen nodes	☐ Yes	☐ No
History of a transfusion	☐ Yes	☐ No
History of Hepatitis	☐ Yes	☐ No

Allergic/Immunologic

Itchy eyes/nose	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No
Pets in the home	☐ Yes	☐ No
Immune disorder	☐ Yes	☐ No

Does your child have:

Trouble sleeping	☐ Yes	☐ No
Frequent awaking	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Restless legs	☐ Yes	☐ No
Sleep walking	☐ Yes	☐ No
Sleep talking	☐ Yes	☐ No
Wetting the bed	☐ Yes	☐ No
Trouble eating	☐ Yes	☐ No
Finicky eating habits	☐ Yes	☐ No
Sinus infections	☐ Yes	☐ No
How many per year?	______________	
Tonsil infections	☐ Yes	☐ No
How many per year?	______________	
Ear infections	☐ Yes	☐ No
How many per year?	______________	
Trouble hearing	☐ Yes	☐ No
How long?	______________	
Speech difficulty	☐ Yes	☐ No
Reflux	☐ Yes	☐ No
Large tonsils	☐ Yes	☐ No
Failure to thrive	☐ Yes	☐ No

Pharmacy you prefer to use: ____

Location: ____