Adventist Health Partners
Keeping you well

PEDIATRIC HEALTH HISTORY FORM

Date:

Child's Name: _____ Age: _____ DOB: _____

Your Name: _____ Relationship to child: _____

Primary Care Provider: _____

Present health concerns: _____

Allergies/Reactions: _____

Medications your child takes daily: _____ Herbs/Home remedies used: _____

PREGNANCY AND NEONATAL

Where was your child born: _____ Is your child: ☐ Biological ☐ Adopted ☐ Stepchild ☐ Other

Medical problems during pregnancy: ☐ No ☐ Yes (specify): _____

Delivery: ☐ Vaginal ☐ Caesarean (why): _____ Birth weight: _____ Birth length: _____

Was your child premature? ☐ No ☐ Yes, weeks: _____ Medical problems after birth: _____

Was your child breastfed? ☐ No ☐ Yes, (for how long): _____ Unusual feeding/dietary concerns? ☐ No ☐ Yes, (specify): _____

Current milk intake: ☐ Cow circle one: non-fat 1% fat 2% fat whole ☐ Soy ☐ Rice Average ounces per day (note 8 oz = 1 cup): _____

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

Any sleep problems: ☐ No ☐ Yes, (explain): _____

INFANCY/CHILDHOOD/ADOLESCENCE

Has your child ever been treated for or diagnosed with:

☐ Asthma _____ ☐ Seizures _____

☐ Wheezing or bronchiolitis _____ ☐ Anemia _____

☐ Seasonal allergies _____ ☐ Broken bone _____

☐ Eczema _____ ☐ Depression/anxiety _____

☐ Food allergies _____ ☐ Heart murmur _____

☐ Recurrent ear infections _____ ☐ Constipation _____

☐ Pneumonia _____ ☐ Chicken pox _____

☐ Urinary tract infection _____ ☐ Attention deficit disorder _____

Other chronic medical conditions: _____

Has your child ever been hospitalized? ☐ No ☐ Yes, (explain): _____

Previous surgeries and dates: _____

List any specialists your child has seen, dates and reason: _____

DEVELOPMENT AND SCHOOL

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

If applicable, age of first menstrual cycle: _____

Did/does your child have delayed development? ☐ No ☐ Yes

How does this child compare to others of his or her age? _____

Did/does your child attend preschool? ☐ No ☐ Yes

What grade is he/she in? _____

Has he/she had any trouble in school? ☐ No ☐ Yes

Does he/she get along with other children? ☐ No ☐ Yes

Does he/she have a best friend? ☐ No ☐ Yes

Any concerns about relationships with teachers? _____

DENTAL AND IMMUNIZATIONS

Please bring your child's immunization records to your appointment.

Has your child had chickenpox? ☐ No ☐ Yes Has your child been vaccinated against chickenpox? ☐ No ☐ Yes

Exposures/Habits: _____

Any concerns about lead exposure (old home/plumbing/peeling paint)? ☐ No ☐ Yes _____

Has your child been seen by a dentist? ☐ No ☐ Yes Last visit: _____ Does he/she get fluoride? ☐ No ☐ Yes

SOCIAL AND HOME

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____ ☐ Siblings (#____) ☐ Grandparents ☐ Other _____

Child's parents are: ☐ Married ☐ Unmarried ☐ Divorced ☐ Other _____ Do any household members smoke? ☐ No ☐ Yes

Mom's occupation: _____ Dad's occupation: _____

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

Is violence at home a concern? ☐ No ☐ Yes Are there guns at home? ☐ No ☐ Yes

Childcare (if applicable): ☐ Parents ☐ Relatives ☐ Babysitter/Nanny Days per week in childcare (not with parent): _____

Pets: ☐ No ☐ Yes _____

How many hours per day does your child spend: Watching TV _____ On the computer_____ Playing video games _____

Hobbies/Extracirricular activities: _____

Sports/exercise: _____ How often: _____ How long: _____

FAMILY HISTORY

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma/Hay fever/Eczema	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Alcoholism/Drug Abuse	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐
Blood disorder (bleeding/clotting problems)	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
Inherited/Genetic diseases	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐

REVIEW OF SYSTEMS

Please review the topics below. Check if you have a concern about your child.

☐ Fevers/chills/excessive sweating
☐ Unexplained weight loss/gain
☐ Squinting
☐ Asymmetric gaze/Crossed eyes
☐ Unusually loud voice/hard of hearing
☐ Mouth breathing/snoring
☐ Bad breath
☐ Frequent runny nose
☐ Problems with teeth/gums
☐ Coughing/wheezing
☐ Nausea/vomiting/diarrhea
☐ Constipation
☐ Blood in bowel movements
☐ Tires easily with exertion
☐ Shortness of breath
☐ Fainting
☐ Bedwetting
☐ Developmental concerns
☐ Relationship with parents
☐ Self-image or self-worth
☐ Other _____

☐ Pain with urination
☐ Discharge: penis or vagina
☐ Headaches
☐ Muscle weakness
☐ Clumsiness
☐ Hay fever
☐ Itchy eyes
☐ Rashes
☐ Unusual moles
☐ Joint pain
☐ Speech problems
☐ Anxiety/stress
☐ Problems with sleep/nightmares
☐ Depression
☐ Nail biting/thumb sucking
☐ Bad temper/breath holding/jealousy
☐ Unexplained lumps
☐ Easy bruising/bleeding
☐ Depression
☐ School grades/absences