Pediatric Health History

Name:____Date of Birth:______________Today's Date:______________

Birth History

☐ Vaginal Delivery ☐ Cesarean Section ☐ Premature Birth- Age at Birth_____ Weeks

Birth Weight_____pounds/ounces Birth Length_____ inches ☐ Other Complications/Comments________________

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Past Medical History (check and comment on any/all that apply)

☐ Abuse/Neglect_________________________________

☐ ADD/ADHD_____________________________________

☐ Allergies_____________________________________

☐ Anemia_______________________________________

☐ Asthma_______________________________________

☐ Autism____

☐ Blood Disorders_______________________________

☐ Cancer____

☐ Cerebral Palsy________________________________

☐ Chickenpox____________________________________

☐ Concussion____________________________________

☐ Congenital Heart Disease______________________

☐ Congenital Malformations______________________

☐ Constipation__________________________________

☐ Croup____

☐ Cystic Fibrosis_______________________________

☐ Developmental Delay___________________________

☐ Diabetes______________________________________

☐ Eczema____

☐ Enuresis (Bed Wetting)________________________

☐ Esophageal Reflux (Heartburn)_________________

☐ Eyesight Problems_____________________________

☐ Fractures_____________________________________

☐ Headaches_____________________________________

☐ Hearing Loss__________________________________

☐ Heart Disease_________________________________

☐ Hyperlipidemia (High Cholesterol)_____________

☐ Hypertension (High Blood Pressure)____________

☐ Immune Disorder_______________________________

☐ Influenza (Flu)_______________________________

☐ Jaundice______________________________________

☐ Kidney Disease________________________________

☐ Liver, Stomach, or Bowel Disease______________

☐ Lung Disease__________________________________

☐ Measles_______________________________________

☐ Mental Illness________________________________

☐ Muscular Dystrophy____________________________

☐ Otitis Media (Ear Infection)__________________

☐ Pneumonia_____________________________________

☐ Pulmonary Embolism____________________________

☐ Scoliosis_____________________________________

☐ Seizure Disorder______________________________

☐ Sickle Cell___________________________________

☐ Skin Problems_________________________________

☐ Sleep Apnea___________________________________

☐ Speech Disabilities___________________________

☐ Spina Bifida__________________________________

☐ Thyroid Disease_______________________________

☐ Tonsillitis___________________________________

☐ Tuberculosis__________________________________

☐ Urinary Tract Infection (UTI)_________________

☐ Urticaria (Hives)_____________________________

☐ Other____

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Surgical History (check and comment on any/all that apply)

☐ Ear Surgery____
☐ Nose Surgery_______________________________________
☐ Throat Surgery_____________________________________
☐ Adenoidectomy (Adenoids)___________________________
☐ Tonsillectomy______________________________________
☐ Thyroid Surgery____________________________________
☐ Cardiac (Heart) Surgery____________________________
☐ Lung Surgery_______________________________________
☐ Abdominal Surgery__________________________________
☐ Appendectomy (Appendix)____________________________
☐ Cholecystectomy (Gallbladder)_______________________
☐ Hernia____
☐ Skin/Dermal Surgery________________________________
☐ Orthopedic Surgery_________________________________
☐ Bladder Surgery____________________________________
☐ Kidney Surgery_____________________________________
☐ Bowel Surgery______________________________________
☐ Other Surgery______________________________________

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Social History

Living Situation

☐ Living with Parents ☐ Living with Relatives (other than Parents) ☐ Living with Grandparents
☐ Other living arragements____

Siblings

☐ Brother(s)- How many?_____ ☐ Sister(s)- How many?_____

Substance Use/Exposure

☐ Exposed to cigarette and/or marijuana smoke at home?____
☐ Alcohol ☐ Cigarettes ☐ Cocaine/Methamphetamine ☐ Marijuana
☐ Other ____

Activities/Exercise

☐ Baseball
☐ Fishing
☐ Football
☐ Running
☐ Soccer
☐ Walking
☐ Track and Field
☐ Bicycling
☐ Cheerleading
☐ Hunting
☐ Gymnastics
☐ Skiing
☐ Swimming
☐ Volleyball
☐ Basketball
☐ Hiking
☐ Golf
☐ Skateboarding
☐ Softball
☐ Wrestling
☐ Other Activities____

Family History (check all that apply)

	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT
Alcoholism					
Anemia					
Asthma					
Autoimmune Disease					
Birth Defects					
Blood Disorders					
Cancer___________________________________					
Crohn's Disease					
Cystic Fibrosis					
Diabetes Mellitus					
Hearing Loss					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Infectious Disease					
Kidney Disease					
Lupus					
Mental Health Issues					
Migraine Headache					
Other_____________________________________					
Sickle Cell Abnormality					
Stroke					
Thyroid Disorders					
Tuberculosis					
Ulcerative Colitis					

Additional Comments

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