University Hospitals
Medical Practices

Pediatric Health History Form

CHILD'S NAME: ____

DATE OF BIRTH: ________________ AGE: ______________________

CHILD'S PEDIATRICIAN/PRIMARY CARE PROVIDER:

____

PRESENT HEALTH CONCERNS:

____

MEDICINES / VITAMINS:

____

____

HERBS / HOME REMEDIES:

____

ALLERGIES / REACTIONS TO MEDICINES OR VACCINATIONS:

____

PREGNANCY & BIRTH

Is the child yours by: birth adoption stepchild other:

____

Please, indicate any medical problems during pregnancy.

none

other: ____

Delivery by: vaginal birth caesarian

If caesarian, why? ______________________________________

If premature, why? _________

Birth weight: ___________ Birth length: _________ APGAR score 1 min _____ 5 min_____

Please indicate any medical problems during the baby's newborn period.

none other __________________

NUTRITION & FEEDING

Was your child breastfed? No Yes If yes, how long? ________________________

Has your child had any unusual feeding/dietary problems? No Yes

If yes, specify:____

Milk intake now: Circle type

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 per night: _________ Naps (number and length): ________________ Any sleep problems?

____

DEVELOPMENT

At what age did your child: sit alone ____ walk alone ____ say words ____

Toilet train (daytime) _____ Girls only: Age at first menstrual period _________

DENTAL HISTORY

Has child been seen by a dentist? No Yes If yes, how often _________ Date of last visit __________

Has child had: filling cap/crown bridge braces other orthodontic work ____________________

PAST MEDICAL HISTORY

Has your child had: chickenpox measles mumps

rubella meningitis tuberculosis (TB)

Please, bring a copy of your child's immunization record to your appointment

Please, describe any major medical problems and their dates:

____

____

____

Hospitalizations / Operations (with dates): ____

____

Broken bones or severe strains / sprains (with dates): ____________________________________

____

Major falls, traumas or other injuries (with dates): ______________________________________

____

FAMILY HISTORY:

Please, circle any family history of the following (indicate who has/had the condition):

Alcoholism / drug abuse Heart disease or stroke before age 60 Seizures

Psychiatric disorder Thyroid disease Kidney Disease

High blood pressure Bleeding / clotting problem Birth defect

Asthma/hay fever/eczema Inherited/genetic diseases

SOCIAL HISTORY

Birthplace: ______________________________ Current (or upcoming) grade: ________________

Who lives at home? Do any of the household members smoke? No Yes

Name	Age	Relationship	Highest Education Level
_________________	_________	_______________	___________________
_________________	_________	_______________	___________________
_________________	_________	_______________	___________________
_________________	_________	_______________	___________________
_________________	_________	_______________	___________________
_________________	_________	_______________	___________________

Are the child's parents: married unmarried separated divorced

If divorced, when? _____________

Parents' occupations: Mother _________________ Father ______________________

Child care situation: parents others (specify who and hours per day)

____

____

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

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

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

TV hours daily ________ Computer hours daily________ Video games hours daily __________

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 ____

Students No Yes ____

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:

If child has more than one symptom on a line, circle the relevant one(s).

Constitutional / Endocrine	Gastrointestinal	Allergy
Fever/Chills/Excessive sweating	Nausea/Vomiting/Diarrhea	Hayfever/Itchy eyes
Unexplained weight loss/gain	Vomiting	Skin
Eyes	Cardiovascular	Rashes/Unusual moles
Squinting/ "crossed" eyes/	Tires easily with exertion	Psychiatric/Emotional
Asymmetric gaze	Shortness of breath	Speech problems
	Fainting	Anxiety/stress
Ears/Nose/Throat	Genitourinary	Problems with sleep/
Unusually loud voice/Hard of	Bedwetting	nightmares
Hearing	Pain with urination	Depression
Mouth breathing/Snoring	Discharge: penis or vagina	Nail biting/thumb sucking
Bad Breath	Neurological	Bad temper/breath holding/
Frequent runny nose	Headache	jealousy
Problems with teeth/gums	Weakness	Blood/Lymph
Respiratory	Clumsiness	Unexplained lumps
Cough/Weeze	Musculoskeletal	Easy bruising/bleeding
	Muscle/Joint pain	

The information that I have provided is to the best of my knowledge, true.

I authorize Dr. ____________________ to speak with or request records from other physicians who, now or in the past, have cared for this child.

I authorize the release of correspondences and/or medical records to other medical providers involved in this child's care.

Signature ____ Date ____________________

Printed name _________________________ Relationship to patient __________________________

Date intake reviewed ___________________Physician's signature ___________________________