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 _____