

PEDIATRIC HEALTH HISTORY

Name: _____ Age: _____ Grade: _____

Date: _____ Teacher: _____

Previous Doctor: _____

Please take a few minutes to complete this medical questionnaire for your child. It will become part of the permanent medical record. All answers are confidential.

BIRTH HISTORY

During pregnancy: _____ Increased blood pressure, _____ pre-eclampsia, _____ toxemia, _____ abnormal sugars, _____ smoking, _____ infection, or other problems? _____

During labor and delivery: _____ fevers, _____ membranes ruptured more than 18 hours, _____ born early or late _____ forceps delivery, _____ vacuum delivery, _____ c-section

Birth Weight: _____ Went home after how many days _____ Breast fed _____ Bottle fed _____
Type formula: _____

Any problems after birth? _____

LIST ALL HOSPITALIZATIONS

Year	Illness
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL SURGERIES

Year	Surgery
_____	_____
_____	_____
_____	_____
_____	_____

PRESENT MEDICATIONS & DOSE

IMMUNIZATIONS & DATES OR AGE

Hepatitis B	_____
HIB	_____
DPT/DTaP	_____
Polio (shot)	_____
Polio (oral)	_____
MMR	_____
Chickenpox	_____

ALLERGIES

Medication	Reaction
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

ENVIRONMENTAL HISTORY (check all that apply)

	Living	Dead	Age	Medical Conditions
Father				
Mother				
Brothers				
Sisters				
Have any other members of either side of the family had children with congenital defects, severe childhood conditions or stillbirths?				

___ Smoke Detector	___ Tobacco Smoke Exposure
___ Car Seat Use	___ Pets in Home (What type? ___)
___ Seat Belt Use	___ Damp Basement
___ Ipecac in Home	___ Mold Growth in Home
___ Hot Water Temperature _____	___ Firewood
___ Stuffing (dust) Mite Precautions	___ Kerosene Heater
___ Medicines/Chemicals Out of Reach	___ Firearms in Home
___ Fluoride in Water	___ Day Care

Father's Occupation: _____
Mother's Occupation: _____
Hobbies: _____

REVIEW OF SYSTEMS (Check all that apply)

NEUROLOGIC

- Seizures
- Headaches
- Dizziness
- Fainting
- Other

EYES

- Poor Vision
- Mattering
- Other: _____

EARS

- Hearing Problems
- Ear Pain
- Ear Infection
- Ear Drainage
- Tubes
- Itching

NOSE

- Runny
- Stuffiness
- Sinus Problem
- Snoring
- Itching
- Sneezing

THROAT

- Sore Throat
- Tonsillectomy
- Difficulty Swallowing

RESPIRATORY

- Asthma or Wheezing
- Croup
- Frequent Cough
- Problems Breathing
- Other: _____

CARDIOVASCULAR

- Heart Murmur
- Turning Blue
- Short of Breath While Feeding
- Excessive Sweating
- Swelling of Abdomen or Feet

LIVER

- Yellow Jaundice
- Gallbladder Problem

GASTROINTESTINAL

- Nausea or Vomiting
- Poor Appetite
- Belly Pain
- Diarrhea
- Constipation
- Tarry or Bloody Stools
- Potty Trained (Stools)

KIDNEY/URINARY

- Kidney Infection
- Bladder Infection
- Difficulty Urinating
- Burning Urination
- Frequent Urination
- Decreased Urination
- Blood in Urine
- Potty Trained (Urine)

INFECTION

- Fever, Chills, Rigors
- Exposure to TB
- Other Significant Exposures: _____

- Meningitis

- Rheumatic Fever
- Chickenpox

MUSCULOSKELETAL

- Joint Pain
- Joint Swelling
- Limping
- Curvature of Back
- Bow Legs
- Knock-Knees
- Club Foot
- Broken Bones
- Hernia

BEHAVIORAL

- Pacifier
- Hyperactivity
- Nightmares
- School Problems
- Social Problems
- Depression
- Anxiety

CUTANEOUS

- Skin Rash
- Skin Infections
- Abnormalities of Skin
- Cavities of Teeth
- Other Teeth Problems

GENERAL

- Weight Loss
- Excessive Weight Gain
- Speech Difficulty
- Poisoning
- Hay Fever or Allergies

ENDOCRINE/METABOLIC

- Diabetes
- Thyroid Disorder
- Growth Problems