PEDIATRIC HEALTH HISTORY (birth to 16 years old)

DATE: **NAME:** **AGE:** **M** **F**

This form is for background health information about your child/ teen-ager and is strictly confidential. 1 PAGE TOTAL.

How may we communicate your results to you? (please circle) **MAIL** **PHONE** **FAX** **ALL**

Who referred you? **Previous physician:**

BIRTH AND PAST MEDICAL HISTORY

PREGNANCY: **Full Term** **Premature** **DELIVERY:** **Vaginal** **C-section** **BIRTH-WT: _____**

Any problems during the pregnancy, labor, delivery, or first few weeks of life? NO YES (please describe)

HOSPITALIZATIONS since birth ? NO YES (please describe)

ILLNESSES your child has had ?: **Asthma** **Chickenpox** **Measles** **Mumps** **Frequent ear infections** **Rubella**

Seizures **Frequent Tonsillitis** **Heart Murmur** **Constipation** **Diarrhea** **Bladder/ Kidney Infection** **OTHER ?:**

MEDICATIONS that your child takes *REGULARLY* ? **NONE**

1. **2.** **3.** **4.**

ALLERGIES to medicine or other allergies ? **NONE**

1. **2.** **3.**

SURGERIES your child has had? **NONE**

1. **2.** **3.**

IMMUNIZATIONS up to date? YES NO (Please bring their shot record to every visit.)

DEVELOPMENT

NORMAL **DELAYED (please describe)**

FAMILY HISTORY for your child / teen-ager, if known.

Foster Child or Adopted? YES NO

		Age	Name	Health Problems
Child's Mother		___	_____	_____
Child's Father		___	_____	_____
Child's Sibling	**M/F**	___	_____	_____
	M/F	___	_____	_____
	M/F	___	_____	_____
	M/F	___	_____	_____

Other family illnesses ?: **diabetes** **high blood pressure** **high cholesterol** **heart disease** **stroke** **arthritis**

kidney disease **deafness** **cancer** **other ?:**

Parent / Caregiver signature: STOP HERE
