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**