PACIFIC GROVE
FAMILY MEDICINE

# PEDIATRIC HEALTH HISTORY

**CHILD'S NAME:** _____ **D.O.B.:** _____ **AGE:** _____

**CHILD'S PREVIOUS DOCTOR/PCP:** _____

**BIRTH AND PREGNANCY**

WHAT CITY WAS YOUR CHILD BORN IN? _____ NAME OF HOSPITAL: _____

IS THIS YOUR CHILD BY: _____ BIRTH _____ ADOPTION _____ STEP-CHILD _____ OTHER: _____

BIRTH WEIGHT: _____ WAS YOUR BABY PREMATURE? **Y / N**

WERE THERE ANY SIGNIFICANT MEDICAL PROBLEMS DURING YOUR PREGNANCY? **Y / N**

WERE THERE ANY SIGNIFICANT COMPLICATIONS DURING LABOR OR THE BABY'S NEWBORN PERIOD? **Y / N**

IF YES, TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN: _____

_____

**GROWTH AND DEVELOPMENT**

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.) ? **Y / N**

If yes, please explain: _____

Girls only: Age at first period: _____

**PAST MEDICAL HISTORY**
**HAS YOUR CHILD:**

| | | | |
|---|---|---|---|
| Had any serious medical illness? | **Y / N** | Had broken bones/frequent or severe sprains? | **Y / N** |
| Had a history of asthma or wheezing? | **Y / N** | Had any mental or behavioral problems? | **Y / N** |
| Ever used an inhaler or nebulizer? | **Y / N** | Had a positive tuberculosis skin test? | **Y / N** |
| Had Surgery? | **Y / N** | Been hospitalized overnight? | **Y / N** |

If yes to any of the above, please explain: _____

_____

**IMMUNIZATIONS** ***Please bring your child's immunization records to your appointment***

Have you ever refused vaccines for your child? **Y / N**

If yes, why? _____

**MEDICATIONS AND ALLERGIES**
Please list current medications, vitamins, and supplements, even those used intermittently : _____

_____

Please list allergies or reactions to medications, vaccines, or foods

| Allergy | Reaction |
|---|---|
| | |
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**FAMILY HISTORY**

Please indicate with a check ( ☑ ) family members who have had any of the following conditions:

| Medical Condition | Mom | Dad | Sister | Brother | Mom's Mom | Mom's Dad | Dad's Dad | Dad's Mom | Mom's Sister | Mom's Brother | Dad's Sister | Dad's Brother |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | | | | | | |
| Anemia | | | | | | | | | | | | |
| Asthma | | | | | | | | | | | | |
| Autism | | | | | | | | | | | | |
| Autoimmune Disorder | | | | | | | | | | | | |
| Birth Defect/Congenital Anomaly | | | | | | | | | | | | |
| Bleeding Problem | | | | | | | | | | | | |
| Cancer, Breast | | | | | | | | | | | | |
| Cancer, Please Specify Type: | | | | | | | | | | | | |
| Cancer, Please Specify Type: | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | |
| Eczema | | | | | | | | | | | | |
| Food Allergy | | | | | | | | | | | | |
| Genetic Disorder | | | | | | | | | | | | |
| Hay Fever (Allergic Rhinitis) | | | | | | | | | | | | |
| Hearing Disorder | | | | | | | | | | | | |
| Heart Attack/Coronary Artery Disease | | | | | | | | | | | | |
| High Cholesterol (Hyperlipidemia) | | | | | | | | | | | | |
| High Blood Pressure (Hypertension) | | | | | | | | | | | | |
| Immune Disorder | | | | | | | | | | | | |
| Inflammatory Bowel Disease (Crohns/UC) | | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | | |
| Mental Retardation or Learning Disability | | | | | | | | | | | | |
| Migraine Headaches | | | | | | | | | | | | |
| Psychiatric/Mental Illness | | | | | | | | | | | | |
| Scoliosis | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | |
| Substance Abuse | | | | | | | | | | | | |
| Thyroid Disorders | | | | | | | | | | | | |
| Tobacco Use | | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | | |
| Death before age 56 or reasons not listed above | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |

**SOCIAL HISTORY:** Please list patient's family and household members:

| Name | Age | Relationship | Occupation/Employer | Phone Number |
|---|---|---|---|---|
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Are your child's parents: ___ Married ___ Unmarried ___ Separated ___ Divorced (If divorced or separated, when? _____

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? ___ Yes ___ No Are there pets in the home? ___ Yes ___ No

Are there guns in the home? ___ Yes ___ No Do any family members smoke? ___ Yes ___ No