PEDIATRIC HEALTH HISTORY
(Newborn-5 years)

Name:_____ Sex: M F Date of Birth:____/____/_____

Birthplace: Hospital:_____ City:_____ State:_____

Parent/Guardian:_____ Phone:_____

PRENATAL/PREGNANCY/DELIVERY HISTORY

Prenatal:

Did you receive prenatal care? Y N Did you attend prenatal classes? Y N

What month of pregnancy did you start prenatal care?_____

Doctor for prenatal care:_____ City:_____ State:_____

Pregnancy (Mother's Health)

Complications (check any that you had during your pregnancy)
___Vaginal Bleeding ___Headaches ___Weight gain over 40 pounds

___High Blood Pressure ___Swelling of feet or ankles ___Gestational Diabetes
Other:_____

Did you consume alcohol during your pregnancy? Y N If yes, amount_____ frequency_____

Did you smoke during pregnancy? Y N If yes, _____packs per day

Did you take any prescription or over the counter drugs during pregnancy? Y N If yes, which medications?
_____

Did you use illegal drugs during pregnancy? Y N If yes, which drugs_____

Labor/Delivery

Gestational age (weeks) at delivery?_____ Was labor induced? Y N Vaginal Delivery C-Section

Were forceps used? Y N Any complications at birth? Y N If yes, explain:_____

Baby's weight at birth_____ Length_____ Apgar (if known)_____

Did your baby have any of the following complications after delivery (check all that apply)

___Seizure ___Jaundice ___Infection ___Congenital Abnormalities ___Vomiting ___Cyanosis

___Difficulty sucking ___Difficulty breathing Other:_____
How long did the baby stay in the hospital after delivery?_____

Was the baby circumcised? Y N Physician:_____

CHILD'S HISTORY:

Current Medical Problems

List any medical problems that you child currently has and when they started:_____

Is your child being treated for a medical condition by another health care provider? If so, describe the condition and the treating provider_____

Does your child have, or have they ever had, any of the following:

___Crossed/Wandering eyes	___Repeated ear infections	___Ear Tubes
___Hearing loss	___Speech problems	___Frequent colds
___Allergies	___Hay fever	___Asthma
___Pneumonia	___Whooping cough	___Heart murmur
___Anemia	___Recurrent vomiting	___Chronic/frequent diarrhea
___Colic	___Headaches	___Seizures
___Scoliosis	___Pain in arm/legs/joints	___Swelling in arm/legs/joints
___Jaundice	___Bed wetting	___Chicken Pox
___Measles	___Rubella	___Mumps
___Polio	___Kawasaki Disease	___Scarlet Fever
___Rheumatic Fever	___Genetic disorder	

Nutrition

Feeding type: Breast___ Times per day_____ Duration_____
Bottle____ Ounces_____ Bottles per day_____ Formula Type_____

Does your child currently use: Vitamins Fluoride

Is your child on solid foods? Y N

Age when cereal started_____ When vegetables started_____ When juices started_____

When meats started_____ When fruits started_____ When eggs started_____

Developmental Milestones

How old was your child when (s)he started doing the following:

___Rolled over by self ___sat by self ___Crawled ___Stood alone ___ Walked by self

___Fed self ___Caught a ball ___Talking ___Toilet training

Current Medications

Please list all prescription and over the counter medications your child is taking

Medication	Dose	Reason	How Long

Allergies

Medications:_____ Foods:_____

Other:_____

Hospitalizations/Surgeries

Hospital	Reason	Date	Physician

FAMILY HISTORY

Parents

Mother_____Age_____

Father_____Age_____

Parents Marital Status: Never Married Married Separated Divorced Widowed

Living arrangements: Live together Live apart

___Birth defects ___Mental Retardation ___DES Exposure ___Headaches ___Allergies

___Cancer ___Heart Disease___Stroke ___High Blood Pressure ___Diabetes

___Asthma ___Hay fever ___Anemia ___Arthritis ___Epilepsy ___Thyroid problem

___Epilepsy ___Hepatitis ___Obesity ___Alcoholism ___Psychiatric Disorder

___Sexually transmitted disease

Housing

Type of home: House Apartment Mobile Home

Do you: Own Rent

How old is your home?_____

Number of people living in home?_____

Child living with: Parent Legal Guardian_____

Number of Bedrooms_____ Bathrooms_____

Water source: Well City Other_____

Heat source: Gas Oil Other_____

Does anyone living in your home smoke? Y N

Thank you for completing this form. The information you provided will be helpful in planning your child's health care.

Signature of person completing form:_____ Date:_____

Relationship to patient:_____

Provider Signature:_____