Pediatric Health History

Legal Name: _____ **Date of Birth:** _____
First Middle Last

Name they like to be called: _____ **Sex:** ☐ Male ☐ Female

Filling out this form
Answering these questions will help the child's provider understand their health and how to best treat them. If you need help filling out this form, the clinic staff will help you.

GENERAL

1. Where was the child born? _____

2. When was the last time the child was **seen by a primary care provider**? _____

   Who did they see? _____

ALLERGIES

3. Has the child had any **allergic reaction (bad effect**) to a medicine or shot?

☐ No ☐ Yes Please write the name of the medicine or shot and the effect it had below.

Medicine child is allergic to	What happens when they take that medicine
EXAMPLE: Penicillin	They get a rash

4. Do they get an **allergic reaction (bad effect)** from any of the following?

☐ No, they have no allergies. ☐ Yes. *Check all that apply*

Allergic to	**What happens**
☐ Latex (rubber gloves)	
☐ Grass or Pollen	
☐ Eggs	
☐ Shellfish	
☐ Other:	

MEDICINES

5. Is the child taking any **prescription medicines?**

☐ No, they do not take any prescription medicines ☐ Yes. Please list on the next page.

Pharmacy: _____ Phone Number: _____

Medicine name	Strength or Amount		How many pills or doses do you take at a time?			
EXAMPLE: Albuterol	90mcg	✕ As needed	morning	noon	dinner	bed
			morning	noon	dinner	bed
			morning	noon	dinner	bed
			morning	noon	dinner	bed
			morning	noon	dinner	bed

6. Do they regularly take any **over-the-counter, vitamins and nutritional supplements**?

☐ No ☐ Yes. Check all that apply and enter "Strength or Amount" for those they are taking.

Name of medicine	Strength or Amount
☐ Pain Reliever (examples: Tylenol, Advil, Motrin, Aleve, Aspirin)	
☐ Vitamins	
☐ Herbal medicine, please list:	
☐ Nutritional supplements, please list:	
☐ Other, please list:	

MEDICAL HISTORY

7. Has the child **ever** had any of the following **health problems**? *Check all that apply.*

☐ ADD/ADHD	☐ Kidney stones
☐ Allergies	☐ Meningitis
☐ Anxiety	☐ Otitis media (recurrent ear infections)
☐ Arthritis	☐ Pneumonia
☐ Asthma (breathing disease)	☐ Prematurity (born too early)
☐ Cancer (type:_____)	☐ Scoliosis (curving of the backbone)
☐ Diabetes (high blood sugar)	☐ Seizures
☐ Eating disorder	☐ Sickle cell (disorder affecting red blood cells)
☐ Eczema (skin problem)	☐ Strep throat (recurrent throat infection)
☐ Headaches	☐ Thyroid disease
☐ Hearing loss	☐ Tuberculosis (TB, lung disease)
☐ Heart murmur (extra noise heart makes)	☐ Urinary infections
☐ Immune deficiency	☐ Varicella (chicken pox)
☐ Inflammatory bowel disease	☐ Vision problem (problems seeing)
☐ Jaundice (skin and eyes turn yellow)	☐ OTHER:

SURGICAL HISTORY

8. Has the child **ever** had **surgery?**

☐ No, they have never had surgery ☐ Yes. *Please list each surgery below.*

Surgery	Date

FAMILY HISTORY

9. Have any of the child's **family members** ever had any of the following health problems?
Check all that apply

	Name	Alive?	*No known history*	*Arthritis*	*Asthma*	*Birth defects*	*Cancer*	*Depression*	*Heart disease*	*High blood pressure*	*High cholesterol*	*Kidney disease*	*Obesity*	*Thyroid disease*	*Stroke*	*Substance Abuse*	*Other*
Mother		☐ Yes ☐ No															
Father		☐ Yes ☐ No															
Sister		☐ Yes ☐ No															
Sister		☐ Yes ☐ No															
Brother		☐ Yes ☐ No															
Brother		☐ Yes ☐ No															
MGM		☐ Yes ☐ No															
MGF		☐ Yes ☐ No															
PGM		☐ Yes ☐ No															
PGF		☐ Yes ☐ No															

MGM=Maternal Grandmother MGF=Maternal Grandfather PGM=Paternal Grandmother PGF= Paternal Grandfather

SOCIAL AND ENVIRONMENT HISTORY

10. Select all that apply

Does anyone in the family smoke?	☐ Yes ☐ No	
Does the child use community resources?	☐ Yes ☐ No	
Is the child in school?	☐ Yes ☐ No	Grade:_____.
Are there any pets in the home?	☐ Yes ☐ No	
Recent travel outside of the area?	☐ Yes ☐ No	
Tobacco exposure inside the home?	☐ Yes ☐ No	
Tobacco exposure outside of the home?	☐ Yes ☐ No	
Is the child adopted?	☐ Yes ☐ No	
Has there been a divorce or separation?	☐ Yes ☐ No	
Any DHS involvement?	☐ Yes ☐ No	
Is the child in foster care or in a group home?	☐ Yes ☐ No	
Is either parent incarcerated?	☐ Yes ☐ No	
Has the child or another child in the home been incarcerated?	☐ Yes ☐ No	

SERVICES

22. Is the child **currently** seeing any other doctors?

Doctor's Name:_____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Doctor's Name:_____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Doctor's Name:_____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Dentist's Name: _____ Type of Doctor: _____

When Last Seen: _____ Phone Number: _____

Anything else we should know?