Referred by Alliance for Kids

# PEDIATRIC HEALTH HISTORY FORM

| NAME OF PATIENT | | | Name of Person Completing Form |
|---|---|---|---|
| DATE | | | Relationship to Patient |
| SEX<br>[ ]MALE [ ]FEMALE | RACE | SOCIAL SECURITY NUMBER | DATE OF BIRTH |

Please list all people in the household:

| | NAME | DATE OF BIRTH | OCCUPATION | EDUCATION |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |

Have there been any recent major changes or stresses in the child's life? [ ]YES [ ]NO
If YES, please explain: _____

Does the child go to a baby-sitter, pre-school or day care regularly? [ ]YES [ ]NO

## BIRTH HISTORY

Birth Weight _____ Length _____ Place _____

During the pregancy did the mother: (if YES, please explain) **Explanation**

- Have any medical problems? [ ]YES [ ]NO _____
- Smoke or drink? [ ]YES [ ]NO _____
- Use any medications? [ ]YES [ ]NO _____
- Use alcohol or other drugs? [ ]YES [ ]NO _____
- Have problems with labor/delivery [ ]YES [ ]NO _____

How long did the baby stay in the hospital after birth? _____

## PAST MEDICAL HISTORY

Is the child's general health: [ ]Good [ ]Fair[ ]Poor (check one) **Explanation**

- Does the child have any allergies? [ ]YES [ ]NO _____
- Is the child taking any medications? [ ]YES [ ]NO _____

Please list any hospitalizations, operations, serious illnesses or accidents.

_____ Date: _____

_____ Date: _____

**Has the child ever had any problems with the following?** **Explanation**

- Eyes/Vision [ ]YES [ ]NO _____
- Feet [ ]YES [ ]NO _____
- Digestion/Nutrition [ ]YES [ ]NO _____
- Ears/Hearing [ ]YES [ ]NO _____
- Urine/Kidneys [ ]YES [ ]NO _____
- Joints [ ]YES [ ]NO _____
- Skin [ ]YES [ ]NO _____
- Lungs [ ]YES [ ]NO _____
- Teeth [ ]YES [ ]NO _____
- Heart [ ]YES [ ]NO _____
- Seizures [ ]YES [ ]NO _____
- Repeated Infections [ ]YES [ ]NO _____

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## Family History

Have any of the child's brothers or sisters died? [ ]YES [ ]NO
(If YES, please give age and cause) _____
Have any of the child's blood relatives had the following diseases: (If YES, please list family member)

| | | Family Member |
|---|---|---|
| Heart Disease | [ ]YES [ ]NO | |
| Tuberculosis | [ ]YES [ ]NO | |
| High Blood Pressure | [ ]YES [ ]NO | |
| Kidney Disease | [ ]YES [ ]NO | |
| Allergies/Asthma | [ ]YES [ ]NO | |
| Cancer | [ ]YES [ ]NO | |
| Diabetes | [ ]YES [ ]NO | |
| Mental/Emotional Problems | [ ]YES [ ]NO | |
| Sickle Cell | [ ]YES [ ]NO | |
| Seizures | [ ]YES [ ]NO | |

## Development

Do you have any concerns about the following? (If YES, please explain)

| | | Explanation |
|---|---|---|
| Development | [ ]YES [ ]NO | |
| Behavior | [ ]YES [ ]NO | |
| Eating Habits | [ ]YES [ ]NO | |
| Sleeping Habits | [ ]YES [ ]NO | |
| School Experience | [ ]YES [ ]NO | |
| Bathroom/Toilet Habits | [ ]YES [ ]NO | |
| Discipline | [ ]YES [ ]NO | |
| Other (explain) | [ ]YES [ ]NO | |

## IMMUNIZATIONS WILL BE COPIED ON IMMUNIZATION RECORD BY OFFICE STAFF

### THIS SECTION IS FOR TEENAGERS AND IS TO BE COMPLETED BY THE TEEN

Do you:

| | |
|---|---|
| Use Tobacco? | [ ]YES [ ]NO |
| Drink Beer or other Alcoholic Beverages? | [ ]YES [ ]NO |
| Use any kind of drugs? | [ ]YES [ ]NO |

(For Females) How old were you when you had your first period? _____

| | |
|---|---|
| Are you sexually active? | [ ]YES [ ]NO |
| If YES, do use birth control/protection? | [ ]YES [ ]NO |
| Have you ever been pregnant or fathered a child? | [ ]YES [ ]NO |

Do you have any concerns about the following? (If YES, please explain)

| | | |
|---|---|---|
| Safety Issues | [ ]YES [ ]NO | |
| Substance Use (drugs, alcohol, tobacco) | [ ]YES [ ]NO | |
| Sexually Transmitted Diseases | [ ]YES [ ]NO | |
| Family Planning | [ ]YES [ ]NO | |
| Other (explain) | [ ]YES [ ]NO | |

Reviewed By: _____ Date: _____