

ABC Pediatrics, Ltd.
Pediatric Health History Form—Initial Visit

Child's Name _____
Your Name _____

Date of Birth _____ Age _____
Relationship to Child _____ Today's date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____
Is the child yours by _birth_ _adoption_ _stepchild_ _other_
Delivery: _vaginal_ _c-section_
Was your child premature? _No_ _Yes_, born at _____ weeks
Birth weight _____ Length _____
Other problems in the newborn period _____

Social History

Who lives in the child's household? _Mom_ _Dad_ _Step_ _____
_Siblings (# _____) _Grandparents_ _Other_ _____
Child's parents are _married_ _unmarried_ _divorced_ _other_
Mom's Occupation _____ Dad's Occupation _____
Childcare _parents_ _relatives_ _daycare_ _babysitter/nanny_
Days per week in childcare (not with parent) _____
Any pets? _Yes_ _No_ _____
Do any household members smoke? _Yes_ _No_

Infancy/Childhood/Adolescence

Has your child ever been treated or diagnosed with: (explain)
Asthma or reactive airway disease _____
Wheezing or bronchiolitis _____
Seasonal allergies _____
Eczema _____
Food allergy _____
Recurrent ear infections _____
Pneumonia _____
Urinary tract infections _____
Seizures _____
Anemia _____
Broken bone _____
Depression/anxiety _____
Heart murmur _____
Constipation _____
Chicken pox _____
Attention Deficit Disorder _____
Other chronic medical conditions _____

Family History

Do any family members have any of the following conditions:
Condition Mother Father Sibling Grandparent

Asthma	-	-	-	-
Allergies	-	-	-	-
Anemia	-	-	-	-
Blood disorder	-	-	-	-
Cancer	-	-	-	-
High cholesterol	-	-	-	-
High blood pressure	-	-	-	-
Heart attack/disease	-	-	-	-
Diabetes	-	-	-	-
Thyroid Disease	-	-	-	-
Kidney disease	-	-	-	-
Seizures	-	-	-	-
Migraines	-	-	-	-
Autism	-	-	-	-
Depression/anxiety	-	-	-	-
Alcoholism	-	-	-	-
ADD/ADHD	-	-	-	-
Other issues	-	-	-	-

Please explain all positives. _____

Has your child ever been hospitalized? _No_ _Yes_ (explain) _____

Previous surgeries and dates _____

Please list any specialist your child has seen, dates and reason:

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

Current medications and dose: _____

Development/Nutrition

Did/does your child have delayed development? _No_ _Yes_
How does this child compare to others his or her age? _____

What grade is he/she in? _____

Has she/he had any trouble in school? _No_ _Yes_

Does he/she get along with other children? _No_ _Yes_

Do any foods disagree with him/her? _No_ _Yes_

Which ones? _____

Does he/she get fluoride? _No_ _Yes_

How many hours per day does your child spend:

Watching TV _____ Computer _____ Video games _____

Hobbies/extracurricular activities _____

Review of systems

Please review the topics listed below. Check if you have a concern about your child:

Physical problem _____
Development _____
Sleep patterns _____
Snoring _____
Diet/nutrition/weight _____
Amt of physical activity _____
Emotional development _____
Relationships with parents _____
Self-image or self worth _____
Depression _____
Anxiety/stress _____
Attention/impulsivity _____
Acting out/behavior issues _____
School grades/absences _____
Other _____

