General Information

Patient's full name:____________________________

Patient's date of birth:________________________

Nickname:____________________________________

Patient's previous doctor:______________________

(Optional) Race:_______________________________

Ethnicity: ☐Hispanic ☐Non Hispanic

Current medications

Please include vitamins, supplements and herbs:

____

____

Allergies

☐ None

☐ Food:_______________________________________

☐ Seasonal:___________________________________

☐ Other:______________________________________

Pregnancy and Delivery

Where was patient born? (State and hospital): _______

____

Is the patient yours by:

☐ Birth ☐ Adoption

☐ Stepchild ☐ Foster child

☐ Other_______________________________________

Pregnancy:

Any medications taken during pregnancy:

☐ None ☐ Prenatal vitamins

☐ Other_______________________________________

____

Please indicate any complications:

☐ None ☐ Group B Strep positive

☐ Preterm labor ☐ Hepatitis B

☐ High blood pressure ☐ Herpes

☐ Gestational diabetes ☐ Preeclampsia/Toxemia

☐ Other_______________________________________

____

Delivery:

☐ Vaginal ☐ Caesarian Section ☐ Breech

Birth weight:____________Birth length:_________

Please indicate any complications:

☐ None ☐ Prolonged delivery

☐ Forceps ☐ Needed oxygen

☐ Jaundice ☐ Phototherapy

☐ Premature & how early?____________________

☐ Admitted to NICU & why?__________________

____

Immunizations **Please bring a copy of your immunization record to your first appointment, or send it by mail or fax with this form.**

☐ Immunizations current

☐ Behind on immunizations & why:_____________

____

☐ Not immunized & why:______________________

____

Family Social History

Who lives at home with patient? (Include parents, siblings, grandparents, etc.)

Household #1

Name	Age	Relationship

Household #2

Name	Age	Relationship

If patient spends time in two households, describe custody arrangements (50/50, etc): _______________

____

____

Parent #1 occupation:___________________________

Parent #1 employer:_____________________________

Parent #2 occupation:___________________________

Parent #2 employer:_____________________________

Pediatrics 5280 Health History Form-Ages 0-8 Years of Age

Past Medical History

☐ Current or previous medical diagnoses:__________
____
____

☐ Hospitalizations & why? (Include age or date):___
____
____

☐ Surgeries & why? (Include age or date):_________
____
____

☐ Injuries, concussions, fractures, stitches, etc:_____
____

Development:

Have you or a previous provider had concerns regarding your child's development (speech, gross motor, fine motor, etc)? ☐ Yes ☐ No

If Yes, please describe:____________________________
____
____

If Yes, has your child had any evaluations or services?
____
____

Nutrition:

☐ Eats a well-balanced diet ☐ Vegetarian

☐ Vegan ☐ Picky eating or nutritional concerns

Milk intake:__________ounces/day (8 oz = 1 cup)

Milk type:_____________________________________

Has your child had any dietary or feeding problems? ☐ Yes ☐ No

If yes, please explain:__________________________
____
____

Sleep: Hours per night:__________________________

Naps if applicable: ______________________________

Where does your child sleep?____________________

Any sleep problems?____________________________
____

Dental: Is the patient seeing a dentist? ☐ Yes ☐ No

How often?____________________________________

Dental problems or concerns:___________________
____

School or Daycare:

Current school or daycare:______________________

Grade level:___________________________________

If daycare, how soften?_________________________

Any concerns about school performance?

☐ Yes ☐ No If yes, please explain:__________
____
____

Social/Emotional History:

Have you or a previous provider had concerns regarding your child's behavior/emotional needs?

☐ Yes ☐ No

If Yes, please describe:__________________________
____
____

If Yes, has your child had any evaluations or therapy?__________________________________
____
____

Activities/Exposures/Habits:

☐ Physical Activity:____________________________
____

☐ Other activities:_____________________________

Number of hours per week of activities:___________

Number of hours per day of screen time (TV, computers, video games, etc.):________________

Any family members smoke (inside or outside)?

☐ Yes ☐ No

Firearms in the home? ☐ Yes ☐ No

If yes, are locked? ☐ Yes ☐ No

Review of All Systems: Please check any current or past medical problems your child has had.

General:

- ☐ Recurrent Fever
- ☐ Excessive sweating
- ☐ Chills
- ☐ Unexplained weight loss
- ☐ Fatigue
- ☐ Unexplained weight gain

Eyes:

- ☐ Wears glasses
- ☐ Wears contacts
- ☐ Lazy eye(s)
- ☐ Crossed eyes

Ears, Nose & Throat:

- ☐ Hearing loss
- ☐ Frequent ear infections
- ☐ Allergies
- ☐ Frequent runny nose
- ☐ Snoring
- ☐ Frequent bloody nose
- ☐ Frequent sore throats or strep throat
- ☐ Problems with teeth and gums

Respiratory:

- ☐ Asthma
- ☐ Chronic cough
- ☐ RAD or wheezing
- ☐ Chest pain
- ☐ Recurrent croup
- ☐ EIB
- ☐ Shortness of breath with exercise

Cardiovascular:

- ☐ Heart murmur
- ☐ Heart defect
- ☐ Fainting
- ☐ Arrhythmia
- ☐ Poor endurance compared to peers

Gastrointestinal:

- ☐ Nausea
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Unexplained vomiting
- ☐ Blood in stools
- ☐ Frequent stomachaches
- ☐ Jaundice
- ☐ Soiling underwear

Genitourinary:

- ☐ Bed wetting
- ☐ Daytime wetting
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ UTI
- ☐ Urinary reflux

Musculoskeletal:

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Head injuries
- ☐ Concussions - If so, indicate the #__________

Neurological:

- ☐ Tension headaches
- ☐ Dizziness
- ☐ Migraine headaches
- ☐ Fainting
- ☐ Seizures
- ☐ Staring spells

Psychiatric, Emotional & Education:

- ☐ ADD/ADHD
- ☐ Developmental delays
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Aggression/Fighting
- ☐ Speech problems
- ☐ Sleep difficulty
- ☐ IEP
- ☐ Learning difficulty
- ☐ Substance abuse

Skin:

- ☐ Eczema
- ☐ Acne
- ☐ Unusual moles
- ☐ Rashes
- ☐ Hives
- ☐ Bruising

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Short stature
- ☐ Precocious puberty

Specific infections (Plus age or date of infection):

- ☐ Chicken pox_______
- ☐ Meningitis____________
- ☐ RSV_____________
- ☐ Tuberculosis__________
- ☐ Whooping cough (Pertussis)__________________

Any other concerns?______________________________

____

____

____

____

 Pediatrics 5280 Health History Form-Ages 0-8 Years of Age

Family History: Please indicate using the following key any family members who at any time in their lives have been diagnosed with any of these conditions. Please indicate if any family members have died from any of these conditions.

KEY-PLEASE USE THE FOLLOWING IDENTIFIERS FOR FILLING OUT THE FAMILY HISTORY

Mother = Mother of Patient	**Brother** = Brother of Patient	**Grandfather** = Patient's Grandfather	**Aunt** = Mother or Father's Sister	**Cousin** = Cousin of Patient
Father = Father of Patient	**Sister** = Sister of Patient	**Grandmother** = Patient's Grandmother	**Uncle** = Mother or Father's Brother	

Mother's Family History

ADHD____
Alcoholism/Substance abuse____
Allergies____
Alzheimer's____
Anemia____
Anxiety____
Asthma____
Childhood asthma____
Arthritis____
Autism____
Autoimmune diseases____
Bipolar disorder____
Birth defect____
Bladder problems____
Bleeding disorders____
Blood diseases____
Cancer (Type)____
Celiac____
COPD____
Developmental disabilities____
Depression____
Suicide____
Diabetes____
Eating disorder____
Educational difficulties____
GI disorders (Reflux, Colitis, Crohn's)____
Hearing loss____
Heart disease____
Heart arrhythmia (Prolonged QT, SVT)____
High blood pressure____
High cholesterol____
Hip dysplasia____
Kidney disease____
Lazy eye (Strabismus)____
Melanoma____
Mental illness____
Migraine headaches____
Obesity/Overweight____
Renal reflux____
Rheumatological disease____
Scoliosis____
Seizures____
Epilepsy____
Stroke____
Sudden cardiac death____
Sudden unexplained death____
Thrombosis (Blood clot)____
Thyroid disease____
Other____

Father's Family History

ADHD____
Alcoholism/Substance abuse____
Allergies____
Alzheimer's____
Anemia____
Anxiety____
Asthma____
Childhood asthma____
Arthritis____
Autism____
Autoimmune diseases____
Bipolar disorder____
Birth defect____
Bladder problems____
Bleeding disorders____
Blood diseases____
Cancer (Type)____
Celiac____
COPD____
Developmental disabilities____
Depression____
Suicide____
Diabetes____
Eating disorder____
Educational difficulties____
GI disorders (Reflux, Colitis, Crohn's)____
Hearing loss____
Heart disease____
Heart arrhythmia (Prolonged QT, SVT)____
High blood pressure____
High cholesterol____
Hip dysplasia____
Kidney disease____
Lazy eye (Strabismus)____
Melanoma____
Mental illness____
Migraine headaches____
Obesity/Overweight____
Renal reflux____
Rheumatological disease____
Scoliosis____
Seizures____
Epilepsy____
Stroke____
Sudden cardiac death____
Sudden unexplained death____
Thrombosis (Blood clot)____
Thyroid disease____
Other____