

**Child Health History for NEW Patients**

**CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_**

**CHILD’S PREVIOUS DOCTOR/PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BIRTH AND PREGNANCY**

What city was your child born in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this your child by: 􀂉 Birth 􀂉 Adoption 􀂉 Step-child 􀂉 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was your baby premature? **Y / N**

Were there any significant medical problems during pregnancy? **Y / N**

Were there any significant complications during labor or the baby’s newborn period? **Y / N**

If yes, to any of the above questions, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**GROWTH AND DEVELOPMENT**

Have you or your prior pediatrician ever had any concerns about your child’s growth or development (speech/language,

social skills, motor skills, etc.)? **Y / N**

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Girls only: Age at first period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

**HAS YOUR CHILD:**

Had any serious medical illness? **Y / N** Had broken bones/frequent or severe sprains? **Y / N**

Had a history of asthma or wheezing? **Y / N** Had any mental or behavioral problems? **Y / N**

Ever used an inhaler or nebulizer? **Y / N** Had a positive tuberculosis skin test? **Y / N**

Had surgery? **Y / N** Been hospitalized overnight? **Y / N**

If yes, to any of the above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IMMUNIZATIONS *Please bring your child’s immunization records to your appointment***

Have you ever refused vaccines for your child? **Y / N**

If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS AND ALLERGIES**

Please list current medications, vitamins, and supplements, even those used intermittently (use back of paper if needed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list allergies or reactions to medications, vaccines or foods

Allergy Reaction

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**SOCIAL HISTORY:** Please list patient’s family and household members:

Name Age Relationship Occupation/Employer Cell Phone Number

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Are your child’s parents 􀂉 Married 􀂉 Unmarried 􀂉 Separated 􀂉 Divorced (If divorced or separated, when?) \_\_\_\_\_\_\_\_\_\_

Are there any custody arrangements or court orders we should know about?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Child-care situation 􀂉 Parents 􀂉 Others (specify who and hours per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Concerns about your child: 􀂉 Alcohol use 􀂉 Tobacco 􀂉 Sexual activity 􀂉 Aggressive behavior

Is violence at home a concern? **Y / N** Are there pets in the home? **Y / N**

Are there guns in the home? **Y / N** Do any family members smoke? **Y / N**

**FAMILY HISTORY:**

□Family history unknown

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family History:** | **Age** | **Alive** | **Deceased/Cause of Death** | **Major Health Problems**  **(heart disease, stroke, cancer, diabetes, arthritis, etc)** |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Brothers |  |  |  |  |
| Sisters |  |  |  |  |
| Grandparents |  |  |  |  |
| Aunts/Uncles |  |  |  |  |

Is there any family history of heart disease, strokes, or sudden death below the age of 50?

Yes\_\_ No\_\_