sansum CLINIC

# PEDIATRIC HEALTH HISTORY

| Patient Name | MRN |
|---|---|
| Sex/Status | Date of Birth |
| Department | Date |

***This form will help us know your child's health history and health care needs. Only the front side of the form need be completed for infants. Both sides of the form should be completed for all other children. Thank you - The Pediatric Staff.***

## IDENTIFYING DATA

| Name of person filling out this form | |
|---|---|
| Relation to child | Is this child adopted? ☐ Yes ☐ No |

## FAMILY HISTORY

| Mother's Name | Age |
|---|---|
| Father's Name | Age |

Parents are (√)
☐ Married ☐ Divorced ☐ Remarried ☐ Separated ☐ Single

Who does child live with? (√)
☐ Mother ☐ Father ☐ Other

Others in the home (Names)

1._____ Age_____ Relationship_____

2._____ Age_____ Relationship_____

3._____ Age_____ Relationship_____

4._____ Age_____ Relationship_____

5._____ Age_____ Relationship_____

Who cares for the child during the day or after school?

Have any family members or relatives had these conditions? (√)

| *Please mark every line* | Yes | No | Don't know |
|---|---|---|---|
| Birth defect/deformity | | | |
| Mental illness/retardation | | | |
| Convulsions/seizures | | | |
| Family or inherited disease | | | |
| Serious or fatal childhood illness | | | |
| Eye or hearing problems | | | |
| Asthma, Hayfever, Eczema or other allergies | | | |
| Tuberculosis | | | |
| Diabetes | | | |
| Thyroid disease | | | |
| Heart attacks under age 50 | | | |
| Heart disease at birth | | | |
| High cholesterol | | | |
| High blood pressure | | | |
| Peptic ulcer | | | |
| Kidney problem | | | |
| Blood/bleeding diseases: Sickle Cell Anemia | | | |
| Accidental poisoning | | | |
| Smoke regularly | | | |
| Drinking problem | | | |
| Drug problem | | | |
| Other health problems | | | |

## BIRTH HISTORY

*Mark with √*

| | Yes | No | Don't know |
|---|---|---|---|
| Did child's mother have any illness or problems (other than morning sickness) during her pregnancy, labor or delivery or take any medications? | | | |
| Was the baby premature | | | |
| Was the baby delivered by Caesarean Section? | | | |
| Did the baby have any breathing problem at birth? | | | |
| Did the baby develop jaundice (yellowing)? | | | |
| Did the baby have a seizure (convulsion)? | | | |
| Did the baby have any other problems at birth or in the first four weeks of life? | | | |
| Did the baby go home from the hospital at the normal time? | | | |
| Birth weight of baby _____lbs._____oz. | | | |

Physician's Comments:

_____

_____

_____

_____

_____

_____

_____

_____

## DEVELOPMENT

| The child | Months of Age |
|---|---|
| sat alone at | |
| walked alone at | |
| toilet trained at | |
| said first word at | |
| two-word sentences at | |

The child's *(please √)*

| | Above Average | Average | Below Average |
|---|---|---|---|
| general health is | | | |
| physical development is | | | |
| emotional development is | | | |
| coordination is | | | |
| activity level is | | | |

Using a few words, how would you describe your child?

Signature:_____ Date:_____ Time:_____ am pm

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| Patient Name | MRN |
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Does your child have any known allergies to medications (i.e. penicillin), foods, insect bites/stings? ☐ Yes ☐ No

| ***Has your child ever had or now have*** √ | Yes | No | Don't Know |
|---|---|---|---|
| Chickenpox | | | |
| Scarlet fever | | | |
| Rheumatic fever | | | |
| Tuberculosis or positive TB test | | | |
| Hepatitis | | | |
| Surgery or operation | | | |
| Hospitalization | | | |
| Eye or vision problems | | | |
| Ear or hearing problems | | | |
| Dental problem | | | |
| Speech problems | | | |
| Recurrent sore throat or tonsillitis | | | |
| Bronchitis or pneumonia | | | |
| Wheezing or asthma | | | |
| Allergic problems | | | |
| Frequent runny nose | | | |
| Recurrent nosebleeds | | | |
| Recurrent skin rashes or eczema | | | |
| Stomach or bowel problems | | | |
| Hernia | | | |
| Bedwetting | | | |
| Urine/kidney problems or infections | | | |
| Anemia or blood problems | | | |
| Heart condition | | | |
| High blood pressure | | | |
| Fainting spells | | | |
| Joint pain or swelling | | | |
| Bone problems/fractures | | | |
| Convulsions/seizures | | | |
| Frequent headaches | | | |
| Other health problems or serious illness | | | |
| **Behavior Problems** | | | |
| Discipline problems or inability to get along w/others | | | |
| Restlessness, fidgetiness or destructiveness | | | |
| Nervousness or unusually fearful | | | |
| Persistently sad or depressed | | | |
| Use of tobacco, drugs or alcohol | | | |
| Sexual activity or molestation | | | |
| Other problems with behavior | | | |
| **For Girls** | | | |
| Vaginal discharge | | | |
| Menstrual periods | | | |
| Began at age_____ | | | |
| Irregularity or problems with periods | | | |

| **Does child (√)** | Yes | No | Don't Know |
|---|---|---|---|
| Have all needed immunizations | | | |
| Take medicine regularly | | | |
| Take fluoride in vitamins or water | | | |
| See dentist regularly | | | |
| Get sex education at home | | | |
| **Would you like Information?** | | | |
| School problems | | | |
| Family/marital problems | | | |
| Sex education | | | |
| Drug or alcohol | | | |
| Other | | | |

Physician's Comments:

Reviewed By:

Physician Signature:_____ Date:_____ Time:_____ am pm