Pediatrics History Form

Dear Parent:

This is a health questionnaire on your child. **Please complete this form. Bring it with you at the time of an appointment.**

Date completed:________________

Child's Name: ______________________________ Date of Birth: ______________________

Mother's Name: ______________________________ Father/ Partner: ______________________

Home Address: ____

Home Phone: __________________________ Work Phone: ______________________________

This child lives with: ❑ Mother ❑ Mother/Father ❑Mother/Partner ❑ Father/Partner ❑ Grandparent/Other

FAMILY HISTORY

1. Mother Age: __________ Current Health: ______________________________________

   Past Health Problems: ____

2. Father/ Partner Age: __________ Current Health: ________________________________

   Past Health Problems: ____

3. Marital Status of Parents: ____

   ____

4. Other Children in Family:

	Dates of Birth	Name	State of Health
•	________	______________________	________
•	________	______________________	________
•	________	______________________	________
•	________	______________________	________

5. Are there cultural or religious practices that might affect your child's medical care? ❑ yes ❑ no

   If yes, please explain: (examples: blood transfusion, dietary rules):____________________

   ____

   ____

6. Is there a history in the **family/ a blood relative** of:

a.	Tuberculosis	❑ yes	❑ no
b.	Diabetes	❑ yes	❑ no
c.	Asthma, hay fever, eczema, allergies	❑ yes	❑ no
d.	Mental Disorder	❑ yes	❑ no
e.	Seizures	❑ yes	❑ no
f.	Hepatitis	❑ yes	❑ no
g.	Heart disease, stroke, high cholesterol	❑ yes	❑ no
h.	Cancer If yes, what kind: ______________________________	❑ yes	❑ no
i.	Birth defects, genetic defects	❑ yes	❑ no
j.	Other serious medical problems	❑ yes	❑ no

PRENATAL HISTORY

1. While pregnant, did mother have:

a.	High blood pressure	☐ yes	☐ no
b.	Bleeding or spotting	☐ yes	☐ no
c.	Kidney Disease	☐ yes	☐ no
d.	Toxemia	☐ yes	☐ no
e.	Gestational diabetes	☐ yes	☐ no
f.	Threatened Miscarriage	☐ yes	☐ no
g.	German Measles (Rubella)	☐ yes	☐ no
h.	Illness other than cold or flu	☐ yes	☐ no
i.	Premature labor	☐ yes	☐ no

2. Were medications or herbs taken during pregnancy? ☐ yes ☐ no
   If yes, what kind: ______________________________

3. Was a fertility treatment used for this pregnancy? ☐ yes ☐ no
   If yes, what kind: ______________________________

BIRTH HISTORY

1. Where was baby born: ______________________________

2. Was labor induced: ☐ yes ☐ no

3. Was labor helped by medication: ☐ yes ☐ no

4. Duration of labor: ______________________________

5. Was baby born early: (less than 38 weeks) ☐ yes ☐ no

6. Was baby born late (after 42 weeks) ☐ yes ☐ no

7. What was the method of delivery ☐ yes ☐ no
   - ☐ Spontaneous vaginal
   - ☐ Forceps
   - ☐ Breech
   - ☐ Caesarean Reason: ______________________________

8. Birth weight of baby: ______________________________

9. Apgar score, if known: ______________________________

10. During hospital stay, did baby have any of the following:

a.	Jaundice	☐ yes	☐ no
b.	Antibiotic treatment	☐ yes	☐ no
c.	Rash	☐ yes	☐ no
d.	Blue spells	☐ yes	☐ no
e.	Convulsions	☐ yes	☐ no
f.	Did baby remain in hospital longer than mother?	☐ yes	☐ no

11. How was baby fed?
    - ☐ Breast
    - ☐ Bottle

DEVELOPMENTAL HISTORY:

1. At what age did child:

		Age
a.	Hold up head	________
b.	Roll over	________
c.	Sit unsupported	________
d.	Stand alone	________
e.	Walk	________
f.	Talk	________
g.	Toilet train	________
h.	Feed her/himself	________
i.	Dress her/himself	________

IMMUNIZATIONS

PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES
and TB (Tuberculosis) Testing or BCG Vaccination

PAST MEDICAL HISTORY:

1. Has the child had:
   - a. Chicken pox ☐ yes ☐ no
   - b. Measles (Rubeola) ☐ yes ☐ no
   - c. German Measles (Rubella) ☐ yes ☐ no
   - d. Mumps ☐ yes ☐ no
   - e. Meningitis ☐ yes ☐ no
   - f. Convulsions ☐ yes ☐ no
   - g. Contusions ☐ yes ☐ no
   - h. Fractures ☐ yes ☐ no
   - i. Poison Ingestion ☐ yes ☐ no
   - j. Operations ☐ yes ☐ no
   - k. Blood transfusions ☐ yes ☐ no
   - l. Blood: anemia (iron deficiency, Sickle Cell, Thalassemia) ☐ yes ☐ no
   - m. Hospitalizations ☐ yes ☐ no
     If yes, what illness? ____________________
   - n. Other serious medical illnesses: ☐ yes ☐ no
     If yes, what kind? ____________________
   - o. Is your child currently taking any medications, vitamins, or herbs: ☐ yes ☐ no

Medications	Strength or dose	How often
________	________	________
________	________	________
________	________	________

   - p. Reaction to drug or foods (allergy) ☐ yes ☐ no
     If yes, please explain: ____________________
     ____
   - q. Any chronic or recurring pain? ☐ yes ☐ no
     If yes, please explain: ____________________
     ____

2. Eyes:
   - a. Any visual problems? ☐ yes ☐ no
   - b. Do eyes look crossed? ☐ yes ☐ no
   - c. Does the child wear glasses? ☐ yes ☐ no

3. Ears:
   - a. Any hearing problems? ☐ yes ☐ no
   - b. Three or more ear infections? ☐ yes ☐ no

4. Nose:
   - a. Does the child have frequent attacks of sneezing or rubbing his/her nose? ☐ yes ☐ no
   - b. Has the child had frequent nose bleeds? ☐ yes ☐ no

5. Throat:
   - a. Does your child have three or more strep throat infections per year? ☐ yes ☐ no

6. Heart:: Have you ever been told your child has:
   - a. A heart murmur ☐ yes ☐ no
   - b. High blood pressure ☐ yes ☐ no
   - c. Heart defect ☐ yes ☐ no

7. Lungs: Has your child ever had:
   a. Bronchitis or pneumonia ❑ yes ❑ no
   b. Asthma/wheezing ❑ yes ❑ no
   c. Chronic cough ❑ yes ❑ no

8. Does your child tire easily? ❑ yes ❑ no

9. Abdomen: Has your child ever had:
   a. Jaundice ❑ yes ❑ no
   b. Blood in bowel movement ❑ yes ❑ no
   c. Frequent abdominal pain ❑ yes ❑ no
   d. Frequent vomiting or diarrhea ❑ yes ❑ no
   e. Marked weight loss ❑ yes ❑ no
   f. Difficulty with appetite or eating?
   If yes, please explain:______________________________________

10. Kidney:
   a. Has your child ever had a urinary tract infection? ❑ yes ❑ no
   b. Has there ever been blood in the urine? ❑ yes ❑ no
   c. Does your child ever wet the bed? ❑ yes ❑ no
   d. Does your child ever complain of burning or frequency of urination? ❑ yes ❑ no

11. Skin:
   a. Any sensitivity or allergy? ❑ yes ❑ no
   b. Eczema or atopic dermatitis? ❑ yes ❑ no
   c. Acne? ❑ yes ❑ no

12. Extremities: Has your child:
   a. Had weakness or paralysis of arms or legs? ❑ yes ❑ no
   b. A persistent limp? ❑ yes ❑ no
   c. Ever worn corrective shoes or braces ❑ yes ❑ no

13. Neurological: Has your child ever had
   a. Frequent headaches ❑ yes ❑ no
   b. Convulsions or seizures ❑ yes ❑ no
   c. Dizziness ❑ yes ❑ no
   d. Fainting ❑ yes ❑ no
   e. Breath holding ❑ yes ❑ no
   f. Temper tantrums ❑ yes ❑ no

14. Is your child
   a. Overactive ❑ yes ❑ no
   b. Impulsive ❑ yes ❑ no
   c. Lacking in self control ❑ yes ❑ no
   d. Does your child have problems with:
      - Peers ❑ yes ❑ no
      - Siblings ❑ yes ❑ no
      - Parents ❑ yes ❑ no
      - Sleep ❑ yes ❑ no
      - Attention span ❑ yes ❑ no
      - Attending school ❑ yes ❑ no
      - Learning ❑ yes ❑ no
      - Mood ❑ yes ❑ no
   e. Are there concerns about physical, sexual, or emotional abuse? ❑ yes ❑ no

(You may call **Mental Health Services** to set up an evaluation at 617-253-2916 for any of the above.)

15. Has your child begun puberty? ❑ yes ❑ no

16. Any other concerns you would like to discuss?________________________________

________________________________ ________________________________

Parent signature Date Provider name Date reviewed