Whole Child Pediatrics
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Pediatric Health History Form

PATIENT LABEL

NAME:

DATE OF BIRTH:

AGE:

Your relationship to child:

Child's previous doctor/primary care provider:

Present health concerns:

Medicines/Vitamins:

Herbs/Home Remedies:

Allergies/Reactions to medicines or vaccinations:

PREGNANCY & BIRTH

Where was your child born?

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:

Please indicate any medical problems during pregnancy

☐ None ☐ Specify:

Delivery by ☐ Vaginal birth ☐ Caesarean

If Caesarean.Why?

Birth weight: Birth length:

APGAR score 1 min. 5 min.

Please indicate any medical problems during the baby's newborn period ☐ None (If premature, how early?)

Other problems:

NUTRITION & FEEDING

Was your child breastfed? ☐ No ☐ Yes

If so, how long?

Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, specify:

Milk intake now: Type ☐ Cow's milk ☐ Nonfat ☐ 1% ☐ 2% ☐ Whole ☐ Soy milk ☐ Rice milk

Average ounces per day (Note: 8 ounces = 1 cup)

SLEEP

Hours per night

Naps (number & length)

Any sleep problems?

DEVELOPMENT

At what age did your child: Sit alone

Walk alone Say words

Toilet train (daytime)

Girls only: Age at first menstrual period

DENTAL HISTORY

Has child been seen by a dentist? ☐ No ☐ Yes

If so, how often?

Date of last visit

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:

☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?

(Old home/plumbing/peeling paint) ☐ **No** ☐ Yes

Do any household members smoke? ☐ **No** ☐ Yes

TV – hours per day

Computers - hours per day

Video games - hours per day

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

Hospitalization/operations (with dates):

Broken bones or severe sprains:

FAMILY HISTORY

Please indicate any deaths of your Immediate family members:

Please indicate family members (parent, sibling, grandparent,aunt or uncle) with any of the following conditions:

ADD/ADHD
Alcoholism
Asthma/COPD
Autism
Bleeding or clotting disorder
Cancer, specify type
Depression/suicide
Diabetes
Genetic disorders
Heart disease
High blood pressure
High cholesterol
PANDAS/PANS
Stroke
Other:

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

If divorced or separated,when?

Mother's Occupation

Mother's Employer

Father's Occupation

Father's Employer

Child care situation ☐ Parents ☐ Others (specify who and how often)

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

Is violence at home a concern? ☐ **No** ☐ Yes

Are there guns in the home? ☐ **No** ☐ Yes

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐ **No** ☐ Yes

Current grade

Name of school

Any concerns about school performance?

Any concerns about relationship with:

Teachers ☐ No ☐ Yes

Peers ☐ No ☐ Yes

If more than 4 years old: does your child have a best friend? ☐ No ☐ Yes

Sports/exercise: Type

How often?

How long (minutes)?

REVIEW OF SYMPTOMS: Please check any current problems your child has on the list below:

General
- ☐ Fevers/chills/excessive sweating
- ☐ Unexplained weight loss/gain

Eyes
- ☐ Squinting/"crossed" eyes/asymmetric gaze

Ears/Nose/Throat
- ☐ Unusually loud voice/hard of hearing
- ☐ Mouth breathing/snoring
- ☐ Bad breath
- ☐ Frequent runny nose
- ☐ Problems with teeth/gums

Cardiovascular
- ☐ Tires easily with exertion
- ☐ Shortness of breath
- ☐ Fainting

Respiratory
- Cough/wheeze
- Chest pain

Gastrointestinal
- ☐ Nausea/vomiting/diarrhea
- ☐ Constipation
- ☐ Blood in bowel movement

Genitourinary
- ☐ Bedwetting
- ☐ Pain with urination
- ☐ Discharge: penis or vagina

Musculoskeletal
- ☐ Muscle/joint pain

Skin
- ☐ Rashes
- ☐ Unusual moles

Allergy
- ☐ Hay fever/itchy eyes

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness

Psychiatric/Emotional
- ☐ Speech problems
- ☐ Anxiety/stress
- ☐ Sleep issues
- ☐ Depression
- ☐ Nail biting/thumb sucking
- ☐ Bad temper/breath holding/Jealousy

Blood/Lymph
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding