Family Health & Wellness Center, P.C.

Comprehensive Health Care for Men, Women and Children

PEDIATRIC HISTORY FORM

GENERAL PATIENT INFORMATION

Date _____

Child/Patient's Name _____

Date of Birth _____ Place of Birth _____

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Who does the child/patient live with? ❑ **Both Parents** ❑ **Mother** ❑ **Father** ❑ **Other:** _____

Number of people in household _____

Why is the child/patient here today? _____

_____

MEDICAL HISTORY

1. Allergies & Reactions

Allergy to Latex? ❑ **Yes** ❑ **No**

If yes, reaction: _____

History of a reaction from anesthesia? ❑ **Yes** ❑ **No**

If yes, reaction: _____

History of a blood transfusion or reaction to transfusion? ❑ **Yes** ❑ **No**

If yes, reaction: _____ Year(s): _____

Please provide a detailed list of any other allergies (i.e., medications, vaccinations, environmental, food, etc.) the child/patient has and reactions experienced from each:

Allergy	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*If more space needed, please continue on back of this page.

Family Health & Wellness Center, P.C.

Comprehensive Health Care for Men, Women and Children

2. Please list any prescription and over-the-counter medications, herbs, and vitamins the child/patient is currently taking:

Name	*Dose*	*Frequency*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*If more space needed, please continue on back of this page.

3. Immunizations – **please provide copy of immunization record**

Has the child/patient received all childhood immunizations? ❑ **Yes** ❑ **No**

4. Has child/patient ever had any of the following?

Chicken Pox	❑ **Yes**	❑ **No**	Gallbladder problems	❑ **Yes**	❑ **No**
Measles	❑ **Yes**	❑ **No**	Ulcers	❑ **Yes**	❑ **No**
Mumps	❑ **Yes**	❑ **No**	Urinary Tract Infections	❑ **Yes**	❑ **No**
Rubella	❑ **Yes**	❑ **No**	Kidney Infections	❑ **Yes**	❑ **No**
Meningitis	❑ **Yes**	❑ **No**	Kidney Stones	❑ **Yes**	❑ **No**
Tuberculosis	❑ **Yes**	❑ **No**	Asthma	❑ **Yes**	❑ **No**
Anemia	❑ **Yes**	❑ **No**	Thyroid Disorder	❑ **Yes**	❑ **No**
Diabetes	❑ **Yes**	❑ **No**	Stroke	❑ **Yes**	❑ **No**
Rheumatic Fever	❑ **Yes**	❑ **No**	Kawasaki Disease	❑ **Yes**	❑ **No**

5. List all Surgeries:

Surgery performed	*Year*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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6. Eye Exam

When was the child/patient's last eye exam?

Date: _____

Where did child/patient complete your last eye exam?

_____

Does child/patient wear glasses or contacts? ❑ **Glasses** ❑ **Contacts** ❑ **Both**

7. Mental Health

Does child/patient currently experience or have a history of anxiety? ❑ **Yes** ❑ **No**

If yes: Symptoms? _____

_____

Frequency? _____

Do child/patient currently experience or have a history of depression? ❑ **Yes** ❑ **No**

If yes: Symptoms? _____

_____

Frequency? _____

Does child/patient currently experience or have a history of any other mental/behavioral problems? ❑ **Yes** ❑ **No**

If yes: Symptoms? _____

_____

Frequency? _____

BIRTH HISTORY

Is the child yours by: ❑ **Birth** ❑ **Adoption** ❑ **Stepchild** ❑ **Other:** _____

Medical problems during pregnancy? ❑ **None** ❑ **Other:** _____

Born by: ❑ **Vaginal birth** ❑ **Cesarean**

If premature, why? _____

Birth weight: _____ Birth length: _____

NUTRITION & FEEDING

During infancy was child fed by: ❑ **Breast** ❑ **Bottle** ❑ **Both**

How many ounces per day? _____

SLEEP PATTERNS

Hours per night: _____

Does the child nap? ❑ **Yes** ❑ **No**

If yes, how many hours per day? _____

DEVELOPMENTAL HISTORY

Age at which child: Sat up _____ Crawled _____ Walked _____ Talked in phrases _____ Toilet trained _____

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DENTAL HISTORY

Does child/patient see a dentist regularly? ❑ **Yes** ❑ **No**

If yes, date of last visit? _____

Does child/patient brush their teeth? ❑ **Yes** ❑ **No**

Does the child/patient floss? ❑ **Yes** ❑ **No**

SOCIAL HISTORY

Does child/patient use tobacco? ❑ **Yes** ❑ **No**

If yes, does child/patient: ❑ **Smoke** ❑ **Chew** ❑ **Both**

If former smoker or chewer, what year did child/patient quit? _____

Are there smokers in the home? ❑ **Yes** ❑ **No**

If yes, how many? _____

Does child/patient use alcohol? ❑ **Yes** ❑ **No**

If yes, what kind (check all that apply)? ❑ **Hard liquor** ❑ **Beer** ❑ **Wine** ❑ **Other: _____**

How many drinks in one sitting? _____ How often? _____

Does child/patient use caffeine? ❑ **Yes** ❑ **No**

If yes, in what form? _____ How often? _____

Does child/patient use any illicit, non-prescription drugs? ❑ **Yes** ❑ **No**

If yes, list drug and method of use for each: _____

_____

_____

Is the child/patient sexually active? ❑ **Yes** ❑ **No**

How many hours does the child/patient spend watching TV or using electronics (i.e., video games, tablets, smart phones, etc.)?

_____ hours per day

Is the child/patient living in a house with lead-based paint? ❑ **Yes** ❑ **No**

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FAMILY HISTORY

Does the child/patient's family have a history of thyroid disorders? ❑ **Yes** ❑ **No**

If yes, please specify. _____

_____

_____

Please fill the following table out to the best of your knowledge:

	If Living Age	Health Status	If Deceased Age	Cause
Father				
Mother				
Siblings				
1				
2				
3				
4				
Children				
1				
2				
3				
4				

Has any blood relative ever had:	YES	Relationship (specify mother or father's side)	Age at Onset
Heart Disease			
Cancer – what kind?			
Glaucoma			
High Blood Pressure			
Asthma			
Osteoporosis			
Epilepsy			
Alzheimer's			
Stroke			
Suicide/Attempt			
Tuberculosis			
Anemia			
Migraine Headaches			
Gout			
Diabetes			
Birth Defects			
High Cholesterol			
Depression			
Emphysema			
Hepatitis			
HIV			

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SYSTEMS REVIEW

In the past month, has the child/patient had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss; how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Chills
- ❑ Excessive sweating

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

HEAD AND NECK
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Earaches
- ❑ Bleeding gums
- ❑ Mouth sores
- ❑ Chronic or recurring headaches
- ❑ Facial Pain
- ❑ Sinus pain/pressure
- ❑ Eye pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Itchiness
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Lump or swelling in neck

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Pain in jaw

SKIN
- ❑ Acne
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Change in moles
- ❑ Hair loss
- ❑ Color changes of skin color
- ❑ Changes in nails

GASTROINTESTINAL
- ❑ Decrease in appetite
- ❑ Increase in appetite
- ❑ Nausea
- ❑ Heartburn
- ❑ Abdominal pain
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Constipation
- ❑ Rectal pain
- ❑ Rectal pain with bleeding

HEART AND LUNGS
- ❑ Chest pain/discomfort/congestion
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Leg pain with exercise
- ❑ Cough
- ❑ Coughing up sputum
- ❑ Coughing up blood
- ❑ Night sweats
- ❑ Wheezing

BLOOD
- ❑ Anemia
- ❑ Clots
- ❑ Easy bleeding
- ❑ Easy bruising tendency

URINARY
- ❑ Pain during urination
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Burning during urination

ENDOCRINE SYMPTOMS
- ❑ Excessive thirst/fluid intake
- ❑ Excessive sweating
- ❑ Hot flashes
- ❑ Feelings of weakness
- ❑ Excessive facial or body hair

NEUROLOGIC/PSYCHOLOGIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Change in personality
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Guilty thoughts
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Headaches
- ❑ Dizziness
- ❑ Lightheadedness
- ❑ Convulsions
- ❑ Confusion/disorientation
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

BREAST
- ❑ Breast pain
- ❑ Nipple Discharge
- ❑ Breast lump

SEXUAL HEALTH
- ❑ Sexual complaints
- ❑ Concerns about inability to conceive

OTHER PROBLEMS
_____
_____
_____
_____
_____
_____

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GIRLS ONLY

- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Excessive bleeding during periods
- ❑ Bleeding between periods
- ❑ Severe menstrual pain
- ❑ PMS
- ❑ Vaginal itching or burning
- ❑ Vaginal discharge
- ❑ Currently pregnant
- ❑ Genital lesion

BOYS ONLY

- ❑ Penile pain
- ❑ Penile discharge
- ❑ Testicular pain
- ❑ Genital lesion