



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:

<i>Allergy</i>	<i>Reaction</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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



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

<i>Name</i>	<i>Dose</i>	<i>Frequency</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gallbladder problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary Tract Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rubella | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Meningitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Stones | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kawasaki Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

5. List all Surgeries:

<i>Surgery performed</i>	<i>Year</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



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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? _____

Does 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