CHRIST COMMUNITY HEALTH

# PEDIATRIC HEALTH HISTORY FORM | INITIAL VISIT

(Over 6 Months)

Child's Name: _____ Date of Birth: _____ Age: _____

Your Name: _____ Relationship to Child:_____

## CHILD'S PAST MEDICAL HISTORY

Where was your child born? _____

Is the child yours by ☐ birth ☐ adoption ☐ stepchild ☐ foster ☐ other

Were there any pregnancy complications? _____

Delivery By: ☐ vaginal ☐ c-section Reason for c-section: _____

Was your child premature? ☐ No ☐ Yes, born at ____ weeks. Birth weight:_____ Length: _____

Other problems in the newborn period: _____

## INFANCY/CHILDHOOD/ADOLESCENCE

Has your child ever been treated for/diagnosed with:

☐ Asthma/wheezing/"reactive airways"
☐ Vision or eye problems
☐ Seasonal allergies or eczema
☐ Food allergy
☐ Recurrent ear infections/ hearing loss
☐ Pneumonia
☐ Urinary tract infections/ kidney problems
☐ Genetic syndrome
☐ Seizures
☐ Anemia/bleeding problem
☐ Heart murmur
☐ High blood pressure
☐ Stomach pain/constipation
☐ Developmental delay/ learning disability
☐ Depression/anxiety/bipolar
☐ ADD/ADHD/behavior problems

Please explain: _____

Other chronic medical conditions: _____

Has your child ever been hospitalized overnight? ☐ No ☐ Yes, please explain: _____

_____

Has your child had any surgeries? Dates? _____

Has your child had any broken bones or injuries? _____

Please list any specialist(s) your child has seen and why? (i.e. dermatologist)

_____

## MEDICATIONS

Does your child have any allergies to medications? (List and describe reaction.)

_____

Is your child on any current medications? ☐ No ☐ Yes, name the medications and dose:

_____

Vitamins: _____ Herbal Supplements: _____ Over-the-counter meds: _____

Has your child received any vaccines/immunizations? ☐ No ☐ Yes, where? _____

## COMMUNICATION NEEDS

Language if other than English: Child: _____ Parent: _____

Would you prefer patient education be provided to you or child by:

☐ Demonstration ☐ Written ☐ Other: _____

## PATIENT RIGHTS

Is there anything we need to know about your religion or culture in order to care for your child?

☐ No ☐ Yes, explain: _____

## SOCIAL HISTORY

Who lives in the household with the child?

| Name | Age | Relationship to Child |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare: ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents): _____

Do any household members smoke? ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV: _____ On the Computer: _____ Playing Video Games: _____

Do you have any concerns about peer or teacher relationships? ☐ No ☐ Yes

Sports/Exercise: _____ How often? How long?_____

## SCHOOL HISTORY

Child's School Name: _____ Grade: _____

Do you have any concerns about school performance? ☐ No ☐ Yes, please explain: _____

_____

Has your child ever been held back? ☐ No ☐ Yes

Does your child have an IEP or 504 plan? ☐ No ☐ Yes

## FAMILY HISTORY

Mother's Job/Occupation: _____ Father's Job/Occupation: _____

Do any family members have any of the following conditions:

| Condition | Mother | Father | Sibling | Grandparent |
|---|---|---|---|---|
| Asthma | ☐ | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ | ☐ |
| Blood disorder/sickle cell | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ |
| Heart attack/disease | ☐ | ☐ | ☐ | ☐ |
| High cholesterol | ☐ | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| Thyroid disease | ☐ | ☐ | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ | ☐ |
| Depression/anxiety/mental illness | ☐ | ☐ | ☐ | ☐ |
| Alcohol Addiction | ☐ | ☐ | ☐ | ☐ |
| ADD/ADHD | ☐ | ☐ | ☐ | ☐ |
| Other: _____ | ☐ | ☐ | ☐ | ☐ |