Jeffrey S.
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Pediatric Health History (complete both pages)

Child's name (please print) _____Today's date _____
Reason for seeing the Doctor _____
When did this problem begin _____

PAST MEDICAL HISTORY

Does your child have any medical problems diagnosed by another doctor? ❑ Yes ❑ No
If yes, list them:_____

ALLERGIES

Is your child allergic to any medications, grasses, pollens, foods, etc.? ❑ Yes ❑ No
If yes, please list:_____

MEDICATIONS

Is your child taking any prescription or over-the-counter medications? ❑ Yes ❑ No If yes, list beginning with the most recent medication or ❑ SEE ATTACHED LIST
Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____
Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____
Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____
Type and Strength_____ Dosage_____Reason for taking_____Prescribing Dr. _____
Has your child ever been hospitalized? ❑ Yes ❑ No If yes, list beginning with the most recent:_____
_____
Has your child had any surgeries? ❑ Yes ❑ No If yes, list beginning with the most recent:_____
_____

BIRTH HISTORY

Was your child premature? ❑ Yes ❑ No If yes, how many weeks?_____
Was your child in the NICU after birth? ❑ Yes ❑ No If yes, for how long?_____

IMMUNIZATION HISTORY

Are your child's immunizations up-to-date? ❑ Yes ❑ No If no, then what shots have been missed?
_____

SOCIAL HISTORY

Who lives at home with the child?_____
Do you have pets? ❑ Yes ❑ No How many and what type?_____

FAMILY HISTORY

Has anyone in your family had symptoms similar to those you are here for today?_____
Had tonsils/adenoids removed? ❑ Yes ❑ No Had recurrent ear infections? ❑ Yes ❑ No
Had tubes placed in the ears? ❑ Yes ❑ No
Asthma ❑ Yes ❑ No Hearing Loss ❑ Yes ❑ No Bleeding problems ❑ Yes ❑ No Seizures ❑ Yes ❑ No
Speech or Language Delay ❑ Yes ❑ No Allergies ❑ Yes ❑ No
Explain YES responses, especially who they are and the age they were first affected:_____
_____
Are your child's parents, brothers and sisters alive and well? ❑ Yes ❑ No If No, explain:_____
_____

(see next page)

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Review of Systems

Has your child had any of the following symptoms recently? Explain next to the question.

Constitutional symptoms

Poor Feeding/Difficulty Feeding ❑ Yes ❑ No _____

Poor Weight Gain ❑ Yes ❑ No _____

Eyes

Frequent Pink Eye ❑ Yes ❑ No _____

Ears, Nose, Mouth, Throat

Frequent Ear Infections ❑ Yes ❑ No _____

Frequent Sore Throats ❑ Yes ❑ No _____

Loud Snoring ❑ Yes ❑ No _____

Frequent Upper Respiratory Infections ❑ Yes ❑ No _____

Cardiovascular

Heart Murmur ❑ Yes ❑ No _____

Respiratory

Shortness of Breath ❑ Yes ❑ No _____

Cough ❑ Yes ❑ No _____

Gastrointestinal

Reflux ❑ Yes ❑ No _____

Vomiting ❑ Yes ❑ No _____

Genitourinary

Bed wetting ❑ Yes ❑ No _____

Frequent urinary tract infections ❑ Yes ❑ No _____

Musculoskeletal

Neck/back pain ❑ Yes ❑ No _____

Arm/leg pain ❑ Yes ❑ No _____

Integumentary

Eczema ❑ Yes ❑ No _____

Sensitive Skin ❑ Yes ❑ No _____

Neurological

Headaches ❑ Yes ❑ No _____

Developmental Delays ❑ Yes ❑ No _____

Seizures ❑ Yes ❑ No _____

Psychiatric

Behavior problems/problems at school ❑ Yes ❑ No _____

Irritability ❑ Yes ❑ No _____

Endocrine

Not on the growth curve for height ❑ Yes ❑ No _____

Not on the growth curve for weight ❑ Yes ❑ No _____

Hematologic/Lymphatic

Bleeding problems ❑ Yes ❑No _____

Allergic/Immunologic

Frequent Allergy Symptoms ❑ Yes ❑ No _____