ABC Pediatrics, Ltd.
Pediatric Health History Form—Initial Visit

Child's Name _____ Date of Birth _____ Age _____
Your Name _____ Relationship to Child _____ Today's date_____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____
Is the child yours by □birth □adoption □ stepchild □other
Delivery: □vaginal □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 or diagnosed with: (explain)

- □ Asthma or reactive airway disease _____
- □ Wheezing or bronchiolitis _____
- □ Seasonal allergies _____
- □ Eczema _____
- □ Food allergy _____
- □ Recurrent ear infections _____
- □Pneumonia _____
- □Urinary tract infections _____
- □Seizures _____
- □Anemia ___
- □Broken bone /concussion _____
- □Depression/anxiety _____
- □Heart murmur _____
- □Constipation _____
- □Chicken pox _____
- □Attention Deficit Disorder _____

Other chronic medical conditions _____
_____
Has your child ever been hospitalized? □No □Yes (explain)
_____
Previous surgeries and dates _____
_____
Please list any specialist your child has seen, dates and reason:
_____
_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)
_____
_____
Current medications and dose: _____
_____
_____

Development/Nutrition

Did/does your child have delayed development? □No □Yes
How does this child compare to others his or her age? _____
_____
What grade is he/she in? _____
Has she/he had any trouble in school? □No □Yes
Does he/she get along with other children? □No □Yes
Do any foods disagree with him/her? □No □Yes
Which ones? _____
Does he/she get fluoride? □No □Yes
How many hours per day does your child spend:
Watching TV _____ Computer _____ Video games _____
Hobbies/extracurricular activities _____

Social History

Who lives in the child's household? □Mom □Dad □Step ___
□ Siblings (# ___) □Grandparents □Other _____
Child's parents are □married □unmarried □ divorced □other
Mom's Occupation _____Dad's Occupation_____
Childcare □parents □relatives □daycare □babysitter/nanny
Days per week in childcare (not with parent) _____
Any pets? □ Yes □ No _____
Do any household members smoke? □ Yes □ No
Is there a gun in the home? □ Yes □ No
Is it locked and separate from ammunition? □ Yes □ No

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Brother	Sister	Paternal Grandfather	PaternalGrandmother	Maternal Grandfather	Maternal Grandmother
Asthma								
Allergies								
Anemia								
Blood Disorder								
Cancer								
High Cholesterol								
High blood pressure								
Heart attack/disease								
Diabetes								
Thyroid disease								
Seizures								
Migraines								
Autism								
Depression/anxiety								
Alcoholism								
ADD/ADHD								
Other issues								

Please explain all positives: _____
_____
_____
_____

Review of systems

Please review the topics listed below. Check if you have a concern about your child:

- □ Physical problem
- □ Development
- □ Sleep patterns
- □ Snoring
- □ Diet/nutrition/weight
- □ Amount of physical activity
- □ Emotional development
- □ Relationships with parents
- □ Self-image or self-worth
- □ Depression
- □ Anxiety/stress
- □ Attention/impulsivity
- □ Acting out/behavior issues
- □ School grades/absences
- □ Other _____