



## PEDIATRIC HEALTH HISTORY

CHILD'S Name : \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Parents Name(s): \_\_\_\_\_

### ALLERGIES AND ADVERSE REACTIONS

(Please state "NONE" if none known)


### MEDICATIONS

What medications are you taking? (including Birth Control Pills, Herbs, Vitamins, Dietary Supplements and Over the Counter)

(Please state "NONE" if not taking any medications)


YES	NO	CHRONIC HEALTH CONDITIONS		YES	NO	SURGERIES
		Irregular Heart Beat				Tonsils Removed
		Congestive Heart Failure				Appendix Removed
		Heart Murmur				Hernia Surgery
		Asthma /RAD				Heart Surgery
		Chronic Bronchitis				Gallbladder Removed
		Epilepsy / Seizures				Abdominal Surgery
		Juvenile Diabetes				Broken Bone Repair
		Thyroid Problems- High or Low				Arthroscopic Surgery
		Kidney Disease				
		Skin Disease				
		Anemia/ Low Blood Count				
		Bleeding Problems				
		Blood Transfusions				
		Cancer- Leukemia, etc				
		ADHD				
		<b>Other:</b>				<b>Other:</b>

### FAMILY HISTORY

YES	NO	DISEASE	RELATIONSHIP TO PATIENT		YES	NO	DISEASE	RELATIONSHIP TO PATIENT
		Heart Attack					Bleeding Problems	
		High Blood Pressure					Sickle Cell Anemia	
		High Cholesterol					Diabetes/High Blood Sugar	
		Asthma					Thyroid Problems	
		Tuberculosis					Glaucoma	
		Liver Disease					Cancer, Type:	

	Kidney Disease				Alcohol Abuse	
	Gout / Arthritis					
	Osteoporosis					
	Stroke					
	Epilepsy / Seizures					
	Anxiety / Depression				<b>Other:</b>	

### OTHER HISTORY

Is your child involved in Sports? \_\_\_\_\_ What kind of sports? \_\_\_\_\_

Are child's immunizations up to date? \_\_\_\_\_ Do you have a copy of their immunization records? \_\_\_\_\_

Does your child have a job? \_\_\_\_\_ How many hours per week? \_\_\_\_\_

Birth weight \_\_\_\_\_ Apgar Scores \_\_\_\_\_ Any complications with birth? \_\_\_\_\_

### SOCIAL HISTORY AND HABITS

The following questions are very important and strictly confidential. Please answer them accurately.

#### Smoking /Alcohol

Have you ever smoked?  Yes  No      Do you use smokeless tobacco?  Yes  No

Do you drink?       Yes  No      How much? \_\_\_\_\_ How often? \_\_\_\_\_

### FEMALE PATIENTS ONLY

Number of Pregnancies \_\_\_\_\_ Number of Deliveries \_\_\_\_\_ Number of Abortions \_\_\_\_\_ Number of Miscarriages \_\_\_\_\_

When was your last period? \_\_\_\_\_ How long was it? \_\_\_\_\_ Any problems? \_\_\_\_\_

Have you ever had a PAP smear? \_\_\_\_\_ Date: \_\_\_\_\_ Have you ever had an **abnormal PAP smear**?  Yes  No

If "Yes", when was the abnormal PAP smear? \_\_\_\_\_ What was the abnormality? \_\_\_\_\_

What kind of treatment did you have? \_\_\_\_\_

The above information is current and correct to the best of my / our knowledge.

I have reviewed the above history with the Patient/Parent

\_\_\_\_\_  
Patient / Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Provider's Initial

\_\_\_\_\_  
Date