Silver Sage Center for Family Medicine

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Pediatric Health History Form

Child's Name: ____ Date of Birth: _____________ Age: ________
Parents/Guardian: ____
Child's Previous Doctor: ________________________________ Phone: _______________________________
Present Health Concerns: ____
____
Medication/Vitamins: ____
Herbs/Home Remedies: ____
Allergies/Reactions to Medications and Vaccinations: ____
____

Pregnancy & Birth

Where was your child born? ____
Is the child yours by : __ Birth __ Adoption __ Stepchild __ Other: ___________________________
Please indicate any medical problems during pregnancy __ None __ Specify: _____________________
____
Delivery by __ Vaginal __ Caesarean If Caesarean, why? ____________________________________
Birth Weight: _________ Birth Length: _________ APGAR score: ___________________________
Please indicate any medical problems during pregnancy. __ None. If premature, how early? _______
____

Nutrition & Feeding

Was your child breastfed? __ No __ Yes If so, how long? ___________________________________
Has your child had any unusual feeding problems? __ No __ Yes If yes, specify: ________________
____
Milk intake now: Type __ Cow's Milk(__ 1% __ 2% __ Whole Milk) __ Soy Milk __ Rice Milk
Average ounces per day (Note: 8oz = 1 cup) ____

Sleep

Hours per night _____________ Naps (Number and Length) ___________________________________
Any sleep problems: ____

Development

At what age did your child: Sit alone _____ Walk _____ Say words _____ Toilet train _____
Girls only: Age of first menstrual period: _____________

Immunization/Infectious Disease: Please bring your child's immunization records to your appointment

Has your child had: __ Chickenpox __ Measles __ Rubella __ Meningitis __ Tuberculosis (TB)

Exposures/Habits: any concerns about lead exposure? (old homes/plumbing/peeling paint) __ N __ Y

Do any household members smoke: __ N __ Y
TV Hours per day ______ Computer hours per day ______ Video game hours per day ______

Past Medical History: Please describe any major medical problems and their dates:

____

____

____

Hospitalizations (with dates): ____

____

Broken bones or severe sprains: ____

____

Social History:

Who lives at home?

Name	Age	Relationship

Are your child's parents __Married __Unmarried __Separated __Divorced If divorced/separated, when?___

Child care situation __ Parents __ Others (specify who and hours per day) ___________________________

Concerns about your child: __Alcohol use __Tobacco __Sexual activity __Aggressive behavior __Drug use

Is violence at home a concern? __Yes __No Are there guns in the home? __Yes __No

School History:

Did/does your child attend preschool: __Yes __No

Current grade ________ Name of school ____

Any concerns about school performance? _______________________________________

If child is over 4 years old, does child have a best friend? __Yes __No

Sports/Exercise

Type of exercise _________________________________ How often _________________

Review of symptoms: Please indicate with an **X** if child has any of the following conditions:

Constitutional

__Fevers/chills

__Unexplained

__weight loss/gain

Cardiovascular

__Tires easily

With exertion

__Shortness of breath

__Fainting

Ears/nose/throat

__Unusually load voice/hard of hearing

__Mouth breathing/snoring

__Frequent runny nose

__Problems with teeth and gums

Respiratory

__Cough/wheeze

__Chest pain

Skin

__Rash

__Unusual moles

Allergy

__Hay fever/itchy eyes

Musculoskeletal

__Muscle/joint pain

Gastrointestinal

__Nausea/vomiting

__Diarrhea

__Constipation

__Blood in bowel movements

Blood/lymph

__Unexplained lumps

__easy bruising/bleeding

Eyes

__Squinting/cross-eyes

__Asymmetric gaze

Neurological

__Headaches

__Weakness

__Clumsiness

Psychiatric/Emotional

__Speech problems

__Anxiety/stress

__Problems with sleep/ nightmares

__Depression

__Bad temper/jealousy