QUAKERTOWN PEDIATRICS

PEDIATRIC HEALTH HISTORY FORM – INITIAL VISIT

Today's Date_____

Child's Name _____ DOB _____ Age_____

Your Name _____ Relationship to child _____

Any allergies to medications? ❑ No ❑ Yes If yes, please list: _____

Describe reaction _____

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 _____weeks

Birth weight_____ Length_____

Complications during pregnancy _____

_____

Medications/Supplements during pregnancy _____

_____

Smoking/Drug Use/Alcohol Use during pregnancy _____

_____

Problems in the newborn period_____

_____

✱ ONLY CONTINUE IF APPLICABLE TO YOUR CHILD ✱

Infancy/Childhood/Adolescence

Has your child ever been treated or diagnosed with:

Asthma/reactive airway disease	❑ No	❑ Yes
Wheezing or bronchiolitis	❑ No	❑ Yes
Seasonal allergies	❑ No	❑ Yes
Eczema	❑ No	❑ Yes
Food allergy	❑ No	❑ Yes
Depression/anxiety	❑ No	❑ Yes
Recurrent ear infection	❑ No	❑ Yes
Pneumonia	❑ No	❑ Yes
Urinary tract infection	❑ No	❑ Yes
Seizures	❑ No	❑ Yes
Anemia	❑ No	❑ Yes
Broken bone	❑ No	❑ Yes
Chicken pox	❑ No	❑ Yes
Attention deficit disorder	❑ No	❑ Yes
Heart murmur	❑ No	❑ Yes
Constipation	❑ No	❑ Yes

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

Any pets? ❑ No ❑ Yes _____

Is your child exposed to any smoke? ❑ No ❑ Yes _____

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparents
Asthma	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Anemia	❑	❑	❑	❑
Blood disorder	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
High cholesterol	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Heart attack/disease	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑
Thyroid disease	❑	❑	❑	❑
Kidney disease	❑	❑	❑	❑
Seizures	❑	❑	❑	❑
Migraines	❑	❑	❑	❑
Autism	❑	❑	❑	❑
Depression/anxiety	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑
ADD/ADHD	❑	❑	❑	❑

Other issues_____

_____

Please explain all positive conditions_____

_____

_____

Please list any other chronic medical condition that we should be aware of _____

_____

Has your child ever been hospitalized? ❑ No ❑ Yes If yes, please explain: _____

_____

Has your child had any surgeries? ❑ No ❑ Yes If yes, please explain: _____

_____

over ➡

Current medications and dosage information:_____

_____

_____

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

- ❑ Physical problem
- ❑ Sleep patterns
- ❑ Diet/nutrition/weight
- ❑ Amount of physical activity
- ❑ Emotional development
- ❑ Relationship with parents
- ❑ Self image or self worth
- ❑ Behavior issues
- ❑ Other _____
- ❑ Development
- ❑ Snoring
- ❑ Depression
- ❑ Anxiety/stress
- ❑ Attention
- ❑ Impulsivity
- ❑ Acting out
- ❑ School grades

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?_____

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 foods?_____

Does he/she get fluoride? ❑ No ❑ Yes

How many hours per day does your child spend: Watching TV _____ Computer _____ Video games _____

Hobbies/extracurricular activities _____

Please list any other concerns or problems that you would like us to be aware of_____

_____

_____

_____

Completed by: _____ Date_____

Relationship to patient