Bayside Family & Sports Medicine

Pediatric Health History Form (Newborn to age 13)

Today's date:_____
Child's Name:_____ Date of Birth:_____
Child's Previous Doctor/Primary Care Provider_____
Present Health Concern_____
Medicines/Vitamins_____
Allergies/Reactions to Medications or Vaccinations_____

Pregnancy and Birth
Where was your child born?_____
Is the child yours by: Birth Adoption Stepchild Other:_____
Please indicate any medical problems during pregnancy:_____
Delivery by: Vaginal Birth or Caesarean, if so why_____
Birth Weight:_____ Birth Length:_____
Please indicate any medical problems during the baby's newborn period:
Premature, how early_____ Other problems_____

Nutrition and Feeding
Was your child breastfed? No Yes if so, how long?_____
Has your child had any feeding/dietary problems? No Yes, Specify:_____
_____

Milk intake now: Type: Cow's milk- (Nonfat 1% 2% Whole Milk) Soy Milk Rice Milk
Average ounces per day (note: 8 ounces = 1 cup)_____

Dental History: Has your child been seen by a Dentist? No Yes, date of last exam_____

Water Source: City or Well_____

Immunizations/Infectious Diseases: Please bring your child's immunization records to you appointment.
Has your child been sick with: Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB)

Exposures/Habits: Any concerns about lead exposure? (Old home/plumbing/peeling paint) No Yes
Do any household members smoke? No Yes
TV-hours per day_____ Computer-hours per day_____ Video games-hours per day_____

Past Medical History: Please describe any major medical problems and their dates:
_____
_____
_____
Hospitalizations/Operations (with dates)_____
Broken Bones or Severe Sprains:_____

School History:
Did/does your child attend school or preschool? No Yes
Current grade_____ Name of School_____
Any concerns about school performance_____
Any concerns about relationship with students No Yes
If over 4yrs old: Does your child have a best friend No Yes
Sports/Exercise: Type_____ How Often_____
How Long (minutes)_____

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Pediatric Health History Form (Newborn to age 13) continued

Family History: Please indicate the current health status of your child's immediate family members:

Conditions:

Alcoholism _____ High Cholesterol _____
Cancer, Specify Type_____ High Blood Pressure_____
Heart Attack _____ Stroke _____
Depression/Suicide _____ Other _____
Diabetes _____

Social History: Who lives at home?

Name Age Relationship

_____
_____
_____
_____
_____

Are your child's parents: Married Unmarried Separated Divorced
If divorced or separated when_____
If applicable, name of Step-parent_____

Mother's occupation_____ Employer_____
Father's occupation_____Employer_____

Concerns about your child: Alcohol use Tobacco Sexual Activity Aggressive Behavior
Is violence at home a concern? No Yes
Are there guns in the home No Yes

Sleep

Hours per night_____ Naps (number and length)_____
Any sleep problems_____

Safety: When your child is in the car does he use an: Infant Seat Booster Seat Seat Belt Only

Review of Symptoms: Please **circle** any current problems your child has on the list below:

Constitutional
Fevers/Chills/Excessive Sweating
Unexplained Weight Loss/Gain
Eyes
Squinting/Crossed Eyes
Ears/Nose/Throat
Unusually loud voice/hard of hearing
Mouth breathing/snoring
Problems with teeth/gums
Cardiovascular
Tires easily with exercise
Shortness of breath
Fainting

Respiratory
Cough/Wheeze
Chest Pain
Gastrointestinal
Nausea/Vomiting/Diarrhea
Constipation
Blood in bowel movement
Genitourinary
Bedwetting
Pain with urination
Discharge: Penis or Vagina
Musculoskeletal
Muscle/Joint Pain
Skin
Rashes
Unusual Moles

Allergy
Hay Fever/Itchy Eyes
Neurological
Headaches
Weakness
Clumsiness
Psychiatric/Emotional
Speech Problems
Anxiety/Stress
Problems with Sleeping/Nightmares
Depression
Nail Biting/Thumb Sucking
Bad Temper/Breath Holding/Jealousy
Blood/Lymph
Unexplained Lumps
Easy Bruising/Bleeding