Pediatric Health History Summary

Patient Name: _____________________________ DOB/Age: _____________ M / F Visit Date: ________

List in Order of Importance your Reason for visit and Concerns are:

1. ____
2. ____
3. ____
4. ____
5. ____

Name of primary care physician: _______________________________ Last visit:____________

Family Background:

Ethnic origin/Race: Mother: __________ Father __________ Child lives with: ______________

Was the child adopted? Y N if Yes: at Age:________ Country of Origin:______________

Parents are: __Married __Living Together __Separated __Divorced __Single __Other:______

	Father	**Mother**	**Siblings**	**Father's Side**	**Mother's Side**
Age if Living					
Reason for Death and Age					
Cancer-Type					
High Blood Pressure					
Heart attack/stroke					
Heart Disease					
Asthma/Allergies					
Tuberculosis					
Auto-Immune Disease					

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Diabetes Mellitus					
Osteoporosis					
Obesity					
Addiction					
Mental Illness					
Other:________					

Pregnancy and Birth History: Fill in blanks, **Yes** (Y), **No** (N), check or circle those that apply

Number of Pregnancy's Before this one: _______	Number of births total: _________	Length of this Pregnancy? ___________weeks	Prenatal Care: Y N, for_____ of 9 months	Age of Mother_____ Father_____
Problems or Illness While Pregnant:				
	Rubella (measles)	Accident/Injury	Bleeding/Anemia	Sugar in Urine
	Excessive Weight	High Blood Pressure	Swelling	Thyroid prob
	Pre-Eclampsia	Gestational Diabetes	Emotional Stress	Other: ________
	Meds or supplements: Y N	Type: _______________ ____________________	Coffee: Y N	Cups per day: ____________
	Alcohol or other drugs: Y N	Type and how much? _____________________ ____________________	Smoking: Y N	How many per day & how long: _________
Birth:				
	Delivered at _____weeks.	Labor Induced? Y N Length of labor_______	Was delivery: Vaginal-C-sec-VBAC	Baby Position at birth:______
	Height: _______	Weight: ________	Apgar Score: ______	
Any complications w/ birth or in first days of life?____				

Did your child have the following Disease (D), Get Immunized (I), or Neither (N) (circle those that apply):

Measles: D I N	Typhoid Fever: D I N	Chicken Pox: D I N	Rheumatic Fever: D I N
Mumps: D I N	Diptheria (DTP, DT, DTap): D I N	TB: D I N	Hemophilus (Hib): D I N
Rubella: D I N	Tetanus: D I N	Small Pox: D I N	Pneumococcous: D I N
Polio: D I N	Whooping Cough: D I N	Hepatitis B: D I N	Other: __________________

Any vaccination reactions: ____

What vaccination schedule is child on? (Please provide a copy of current immunization record)

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_____Standard and Up to date _______Delayed or Selective _____Choosing not to Vaccinate

List All Surgeries & Hospitalizations, including date occurred:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Please Note When & Why You Have Had Each of the Following:

Xrays:____________________ MRI/Cat Scans:____________________

Ultrasounds: ____________________ Accidents: ____________________

TB Test: ____________________ Urine test: ____________________

Last Blood Work: ____________________ Other: ____________________

Nutrition (Infant through Childhood):

Breastmilk: Duration ______ weeks / months /years Current Avg # of Nursing / 24 hours _____

Formula: Age started_____ Brand ________________ Oz. per Day _______ Use of pacifier or bottle?

Solid Food introduced at age ___________

Typical Breakfast___________________ Lunch___________________ Dinner_______________ Snack____

Fluids __________________ Thirst level ____________ Favorite foods______________________

Exercise:

How often does child exercise? ____________ For how long? _____________

What type of exercise? _________________________________Hobbies: ___________________________

Time spent watching TV, Computer or Video Game per day __________________________

Sleep:

Bedtime is ___:___p.m. Wakes ____ times a night. Reason for waking in night: ________________

Wake time is ___:____a.m. Does child have problems falling asleep? ________________________

Child's sleeping arrangement (with who, where, position) ____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

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Medications (Please give full name, dosage, and how long you have been taking the medication)

Name Dose When/How Often What Purpose

____

____

____

____

Supplements/Vitamins/Herbs

Name Dose When/How Often What Purpose

____

____

____

Review of Systems:

Present Weight: ____________________ **Weight one year ago**:______________________

Height:____________________________

Any Known Allergies to food, drugs, environment, animals or other: ______________________________

REGARDING THE NEXT LONG SECTION: Please circle (**Y)** if **YES** it is a **PRESENT** problem, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST.**

Good Energy: Y N P **Fatigue**: Y N P

If child fatigued or lethargic, when is it the worst in morning, afternoon, evening? _______________

Is it: Constant or Frequent? __________Can the child do what they need to during the day? Y N

SKIN			
Rash:	Y N P	**Diaper Rash:**	Y N P
Hives:	Y N P	**Psoriasis/Eczema:**	Y N P
Perspiration:	Y N P	**Itchy/Dry:**	Y N P
Cancer:	Y N P	**Warts/moles:**	Y N P
HEAD			
Headache/Migraine:	Y N P	**Head Injury:**	Y N P
Dandruff:	Y N P	**Cradle cap:**	Y N P
Oil/dry hair:	Y N P	**Hair loss:**	Y N P
NOSE			

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Frequent Colds (>6 per year):	Y N P	**Nosebleeds:**	Y N P
Stuffy / Runny nose:	Y N P	**Allergies / Hay fever:**	Y N P
	EYES		
Dry/Watery:	Y N P	**Pink eye:**	Y N P
Double Vision	Y N P	**Crossed Eyes:**	Y N P
Blurry Vision:	Y N P	**Itchy:**	Y N P
Vision Tested:	Y N P	**Glasses or Contacts:**	Y N P
	EARS		
Frequent ear infections: ___ per Year	Y N P	**Loss or trouble Hearing:**	Y N P
Hearing Tested:	Y N	**Hearing Aids:**	
	MOUTH/THROAT		
Thrush:	Y N P	**Cold sores:**	Y N P
Sore Throat:	Y N P	**Strep Throat / Tonsillitis:**	Y N P
Teething difficulties:	Y N P	**Cavities:**	Y N P
Speech difficulties:	Y N P	**Last Dental Visit:**	
	NECK		
Stiffness:	Y N P	**Swollen Glands:**	Y N P
Full movement:	Y N P	**Tension:**	Y N P
	RESPIRATORY		
Cough:	Y N P	**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P	**Wheezing:**	Y N P
Asthma:	Y N P	**Pneumonia:**	Y N P
	CARDIOVASCULAR		
Murmurs / Arrhythmias:	Y N P	**Anemia:**	Y N P
Congenital defects:	Y N P	**Rheumatic Fever:**	Y N P
Heart Disease:	Y N P	**Blood Transfusion: Age______**	Y N P
	URINARY TRACT		
Bed Wetting (after age 5):	Y N P	**Frequent urination/ accidents:**	Y N P
Urine red, brown or discharge:	Y N P	**Urinary tract Infections:**	Y N P
	GASTROINTESTINAL		
Gastric Reflux:	Y N P	**Bowel Movement Freq:**	________
Diarrhea / Constipation:	Y N P	**Recent BM Change:**	Y N P
Bloating:	Y N P	**Stomach ache:**	Y N P
Colic:	Y N P	**Vomiting:**	Y N P
Appetite: Change / Poor	Y N P	**Excessive Weight Gain:**	Y N P
	GENITALIA		
Early Puberty (before age 9):	Y N P	**Sexually Active:**	Y N P
Other: ________________________	Y N P		

Patient Name:____ Todays Date: ____________________

MUSCULOSKELETAL			
Fracture / Break bone:	Y N P	**Joints Pain / Swelling / Arthritis:**	Y N P
Coordination Problem:	Y N P	**Weakness:**	Y N P
NERVOUS			
Seizures / Epilepsy / Convulsions:	Y N P	**Fainting / Dizziness:**	Y N P
Loss of Consciousness:	Y N P	**Other**: ________________	Y N P
MENTAL / EMOTIONAL			
Depression:	Y N P	**Anger/irritability:**	Y N P
Behavioral Problems:	Y N P	**Hyperactive / High strung:**	Y N P
Anxiety:	Y N P	**Fear / Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Antibiotics: # of uses ________ Age and Reason:____

Toxin Exposure:
Did you live near any refinery, polluted area or in a home with leaded paint? Describe:___________________

Has child been exposed to solvents, heavy metals, fumes or other toxic materials? _____________________

Has child had health problems when you painted, put in new carpeting, new cabinets or did other refurbishing?

____

Is child particularly sensitive to perfumes, gasoline or other vapors? ___________________________________

Do you use pesticides, herbicides or other chemicals around your home? ______________________________

Development and Social Life:
At what age did your child: Roll over____ Sit alone____ 1st Tooth____ Walk alone____ Self Feed____

Talk (2-3 word sentences)____ Dress Self____ Toilet trained: Day____ Night_____

If in school, Current grade:_____ Days missed ____ per year Is school enjoyable for child?___________

School issues: Learning (reading, writing, other_________). Behavior_____. Special Needs_____________

Other____

General Mood: _________________Description of Personality: __________________________________
Quality of significant relationship: __________________________

History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom:

____

Your greatest health concern for your child:

____

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How does this limit you or your child the most:

____

Please list the 5 most significant, stressful events in child's life, from the most recent to the most distant. Please circle the most significant one.

1. ____
2. ____
3. ____
4. ____
5. ____

How committed are you towards making valuable changes: Little Moderately Very

The hereby state that the above information is complete and correct to the best of my knowledge:

________________________________ ________________ ______________
Signature Relation to patient Date

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