Print Form

RIGHT from the START PEDIATRICS

Referred by: _____

Form completed by (relation): _____

HEALTH HISTORY FORM

Please fill out this form to the best of your knowledge. If you don't remember something, leave it blank.

CHILD'S FULL GIVEN NAME _____ **ADDRESS** _____

DATE OF BIRTH _____ **CITY** _____

SOCIAL SECURITY NUMBER _____ **STATE/ZIP** _____

ANY ACUTE PROBLEMS OR CONCERNS TODAY? _____

Pregnancy and Delivery History

(CHECK HERE IF CHILD IS ADOPTED ☐ OR UNDER FOSTER CARE ☐)

Mom's age when pregnant with this child _____

Total number of pregnancies _____

Any abortions, miscarriages, deaths? _____

During the pregnancy with this child, was/were there… (if yes, please specify)

Any infections? ----------	YES ☐	NO ☐	_____
Any medical problems or complications? ----------	YES ☐	NO ☐	_____
Tobacco use? (how much and how often) ----------	YES ☐	NO ☐	_____
Alcohol use? (how much and how often) ----------	YES ☐	NO ☐	_____
Illegal drug use? (Which drug and how often?) ----------	YES ☐	NO ☐	_____
Prescription / non-prescription drug use? (Which one(s)?)	YES ☐	NO ☐	_____
Vitamin or supplement use? (Which one(s)?) ----------	YES ☐	NO ☐	_____

Rupture of Membranes ("water breaking") --- By itself ☐ or With help from doctor ☐

Clear fluid or meconium present? ---------- Clear ☐ or Meconium ☐

Labor onset ---------- Spontaneous ☐ Induced ☐ Premature ☐ Late (> 42 weeks) ☐

Any labor complications? (please explain briefly) _____

Presentation ---------- Head first (vertex) ☐ Feet first (breech) ☐

Delivery Mode ---------- Vaginal ☐ C-section ☐

Do you know the reason for the c-section? _____

Any other complications with delivery? _____

Birth History

Born where (hospital and city/state?) _____

Gestational age (weeks pregnant at delivery) _____

Birth weight (in pounds and ounces) _____

Resuscitation required (if known) ---------- Oxygen ☐ Medications ☐ Other ☐

Feeding method ? ---------- Breast ☐ Bottle ☐ Both ☐

Feeding difficulty? ---------- YES ☐ NO ☐

Breathing problems? ---------- YES ☐ NO ☐

Other problems after delivery? _____

Circumcised? ---------- YES ☐ NO ☐

Social History - WHO LIVES IN YOUR HOUSEHOLD?

Name	Age	Relation to patient	Highest level of education	Occupation

Biological parents are: ---------- Married ☐ Unmarried ☐ Divorced ☐ Separated ☐

Any pets? YES ☐ NO ☐ (specify type)

Do any of the patient's caregivers smoke? (at all)	YES ☐ NO ☐	
Alcohol in home (number of days used, per week)?	YES ☐ NO ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐
Guns in home? ----------	YES ☐ NO ☐	
Ammunition locked away in separate place? --------	YES ☐ NO ☐	
Any concern for violence in the home? ----------	YES ☐ NO ☐	

Caregivers other than parents

Name of day care or preschool (N/A if does not attend)

Educational history (CHECK HERE IF HOME SCHOOLED ☐)

Current grade ----------

Name of school (enter HOME if home-schooled)

Any concerns about school? YES ☐ NO ☐
Any concerns about friends? YES ☐ NO ☐
Any concerns about drugs/alcohol? YES ☐ NO ☐
Any problems with teachers/students? YES ☐ NO ☐
Does your child exercise? YES ☐ NO ☐
What activities does your child participate in? (list here)

Seat belt use? YES ☐ NO ☐
Helmet use? YES ☐ NO ☐
Protective gear with skateboard, scooter, etc. YES ☐ NO ☐
Trampoline use? YES ☐ NO ☐

Medications (Check here if none ☐)

Medication	Dose taken?	When taken?	When started?

Allergies (CHECK HERE IF NONE ☐)

Drug, Food, or Other agent	Reaction	Date discovered?

Has your child ever been hospitalized, undergone surgery, or sustained an injury which required a trip to a doctor or hospital? Please list below, with date (approximate is OK) and location:

Past Medical and Family History

PLEASE COMPLETE THE FOLLOWING. PUT AN "X" IN THE APPROPRIATE BOX AND FILL IN ANY DETAILS YOU KNOW.

medical problem	patient	mom	dad	mom's side	dad's side	which relative? comments or any details about illness
ALCOHOLISM	☐	☐	☐	☐	☐	
ALLERGIES	☐	☐	☐	☐	☐	
ANEMIA	☐	☐	☐	☐	☐	
ARTHRITIS	☐	☐	☐	☐	☐	
ASTHMA	☐	☐	☐	☐	☐	
BIRTH DEFECTS	☐	☐	☐	☐	☐	
BLEEDING DISORDERS	☐	☐	☐	☐	☐	
BONE / JOINT DISORDERS	☐	☐	☐	☐	☐	
CANCER (TYPE?)	☐	☐	☐	☐	☐	
DIABETES	☐	☐	☐	☐	☐	INSULIN ☐ or NON-INSULIN ☐
DRUG ABUSE	☐	☐	☐	☐	☐	
EAR PROBLEMS	☐	☐	☐	☐	☐	
EMPHYSEMA	☐	☐	☐	☐	☐	
EYE DISEASE	☐	☐	☐	☐	☐	
HEARING LOSS	☐	☐	☐	☐	☐	
HEART PROBLEMS	☐	☐	☐	☐	☐	
HEPATITIS	☐	☐	☐	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	
HIGH CHOLESTEROL	☐	☐	☐	☐	☐	
HIV / AIDS	☐	☐	☐	☐	☐	
KIDNEY PROBLEMS	☐	☐	☐	☐	☐	
LIVER PROBLEMS	☐	☐	☐	☐	☐	
LUNG PROBLEMS	☐	☐	☐	☐	☐	
MUSCLE PROBLEMS	☐	☐	☐	☐	☐	
PSYCHIATRIC ILLNESS	☐	☐	☐	☐	☐	
RHEUMATIC FEVER	☐	☐	☐	☐	☐	
SEIZURES	☐	☐	☐	☐	☐	
SICKLE CELL	☐	☐	☐	☐	☐	
SKIN DISEASE	☐	☐	☐	☐	☐	
STROKE	☐	☐	☐	☐	☐	
VENEREAL DISEASE	☐	☐	☐	☐	☐	

Other: Please specify here

Thank you for completing this form. Please sign below to certify that you have answered all of the questions to the best of your ability, and that you understand that any omissions, intentional or not, or incorrect information may put your child's health at risk.

Parent/guardian signature

Date (MM/DD/YYYY)

Relationship to child