Pediatric Health History Form

Clear Medical Clinic
13SWS/AFSPC/USAF
Clear, AK 99704

NAME:____________________
D.O.B.:__________ Age:________
Date Form Completed:_________

Your name:

Relationship to child:

Child's previous doctor/primary care provider:

Present health concerns:

Medicines/Vitamins:

Herbs and Home Remedies:

Allergies/Reactions to medicines or vaccines:

____

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 birth ☐ Caesarean

If Caesarean, why?______________
Birth weight:______________
Birth length:______________

Please indicate any medical problems during the baby's newborn period:
☐ None
Other problems:______________
(If premature, how early?)

NUTRITION & FEEDING

Was your child breastfed?
☐ No ☐ Yes
If so, how long?______________

Has your child had any unusual feeding/dietaryproblems?
☐ No ☐ Yes
If yes, specify:______________

Current milk intake & type -
☐ Cow's milk ☐ Nonfat
☐ 1% fat ☐ 2% fat ☐ Whole
☐ Soy milk ☐ Rice milk

Average ounces per day (Note: 8 ounces = 1 cup)______________

SLEEP

Hours per night______________
Naps (number & length)______________
Any sleep roblems? ______________

DEVELOPMENT

At what age did your child:
Sit alone____ Walk alone____
Say words___ Toilet train (daytime)___
Girls only:
Age at first menstrual period_______

DENTAL HISTORY

Has child been seen by a dentist?
☐ No ☐ Yes
If so, how often?______________
Date of last visit ______________

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:
☐ Chickenpox ☐ Measles
☐ Mumps
☐ Rubella ☐ Meningitis
☐ Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure? (old home/plumbing/peeling paint)
☐ No ☐ Yes

Do any household members smoke?
☐ No ☐ Yes

TV – hours per day_______
Computers – hours per day_______
Video games – hours per day_______

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

Hospitalization/operations (with dates):

Broken bones or severe sprains:

FAMILY HISTORY

Please indicate any deaths of your immediate family members:

____

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

- ☐ Alcoholism
- ☐ High cholesterol
- ☐ Cancer, specify type
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Depression/suicide
- ☐ Bleeding or clotting disorder
- ☐ Genetic disorders
- ☐ Asthma/COPD
- ☐ Diabetes
- ☐ Other:

SOCIAL HISTORY

Who lives at home?

Name Age Relationship Highest Education Level

Are your child's parents

☐ Married ☐ Unmarried

☐ Separated ☐ Divorced

If divorced or separated, when?_____

Mother's Occupation______________

Mother's Employer______________

Father's Occupation______________

Father's Employer______________

Child care situation :

☐ Parents ☐ Others (specify who and how often)________________

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

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:

Teachers ☐ No ☐ Yes

Peers ☐ No ☐ Yes

If more than 4 years old: does your child have a best friend? ☐ No ☐ Yes

Sports/exercise: Type__________

How often?________________

How long (minutes)?__________

REVIEW OF SYMPTOMS

Please check any current problems your child has on the list below:

General
☐Fevers/chills/excessive sweating
☐Unexplained weight loss or gain

Eyes
☐Squinting/"crossed" eyes/asymmetric gaze

Ears/Nose/Throat
☐Unusually loud voice/hard of hearing
☐Mouth breathing snoring
☐Bad breath
☐Frequent runny nose
☐Problems with teeth/gums

Cardiovascular
☐Tires easily with exertion
☐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
☐Sleep issues
☐Depression
☐Nail biting/thumb sucking
☐Bad temper/breath holding/jealousy

Blood/Lymph
☐Unexplained lumps
☐Easy bruising/bleeding