Healthy Family Services OF Texas

PEDIATRIC HEALTH HISTORY FORM

Please fill out this form as completely as possible.

Child's Name: _____ **Date of Birth:** _____

Mother's Name: _____ **Father's Name:** _____

Form Filled Out By: _____ **Date:** _____

CHILD'S PAST MEDICAL HISTORY

Pregnancy / Newborn Period

Where was your child born? _____

Child is yours by: ☐ birth ☐ adoption ☐ stepchild ☐ other

Pregnancy complications: _____

Delivery method: ☐ vaginal ☐ c-section Reason for c-section: _____

Was your child premature? ☐ No ☐ Yes, born at _____ weeks

Complications: _____ Birth weight: _____

Other newborn problems: _____

Infancy / Childhood / Adolescence

Has your child ever been treated for or diagnosed with any of the following conditions? (Explain below if checked)

- ☐ Asthma or reactive airway disease: _____
- ☐ Wheezing or bronchiolitis: _____
- ☐ Seasonal allergies or eczema: _____
- ☐ Food allergy: _____
- ☐ Recurrent ear infections: _____
- ☐ Pneumonia: _____
- ☐ Urinary tract infections: _____
- ☐ Genetic syndrome: _____
- ☐ Seizures: _____
- ☐ Anemia: _____
- ☐ Broken bone (fracture): _____
- ☐ Intellectual or learning disability: _____
- ☐ Depression / anxiety: _____

Other chronic medical conditions: _____

Has your child ever been hospitalized? ☐ No ☐ Yes Explain: _____

Previous surgeries and dates: _____

Previous pediatrician: _____ Did child receive vaccines at this office? ☐ Yes ☐ No

Please list any specialist your child is currently seeing and the reason:

_____

MEDICATIONS AND ALLERGIES

ALLERGIES to medicine / vaccines (list and describe reaction):

_____

Current medications and dose: _____

Vitamins: _____ Herbal supplements: _____

Over-the-counter (OTC) medications: _____

DEVELOPMENT AND NUTRITION

At what age did your child begin to:
Sit alone: _____ Walk alone: _____ Say words: _____
Toilet train (day): _____ 1st period (females): _____
Has your child had any unusual feeding or dietary problems? Explain:
_____

SOCIAL HISTORY

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step-parent ☐ Siblings (Count: ___) ☐ Grandparents ☐ Other
Mother's occupation: _____ Father's occupation: _____
Parents' marital status: ☐ married ☐ unmarried ☐ divorced ☐ other
Childcare arrangements: ☐ parents ☐ relatives ☐ daycare ☐ babysitter
Days/week in childcare (not with parents): _____ School name: _____ Grade: _____
Any concerns about school performance? ☐ No ☐ Yes Explain: _____
Do any household members smoke? ☐ Yes ☐ No
How many hours per day does your child spend on: Watching TV: _____ Computer: _____ Video games: _____
Sports / Exercise (Type): _____ How often?: _____ Hours per week: _____

FAMILY HISTORY

Do any family members have any of the following conditions? (Check all that apply)

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack / disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression / anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD / ADHD	☐	☐	☐	☐

Please explain all positive results:

_____