

** please complete as much as possible.

Pediatric Health History
(0 - 15 years)

South Oaks Medical Center

Name: _____ DOB: ____/____/____ Sex: M F

Person completing form & relationship: _____

Check all items that apply to your child and fill in blanks as needed.

Newborn to 3 months (fill in this section only now; additional history to be completed later):

Mother's age at pregnancy? _____ yrs. Medications during pregnancy? _____

Any illness during pregnancy? Yes, explain _____ No

Did mother smoke, use street drugs or alcohol during pregnancy? Yes, explain _____ No

Was baby: Full term or Premature, _____ wks. Type of delivery: Vaginal C-section

Birth weight: _____ lbs. _____ oz. Length: _____ in. Apgar rating: _____

Complications for mother or child during labor, delivery or newborn period: _____

Did child receive 2 newborn screens (heel sticks) before 2 weeks of age? Yes No Unknown

Did newborn receive a hepatitis B shot in the hospital? Yes No Unknown Hospital _____

Past Medical History:

- Allergies (other than drugs), _____
- Anemia or Blood problems
- Arthritis
- Asthma
- Birth defects
- Blood transfusion, what year _____
- Cancer/Tumor, explain _____
- Chicken Pox
- Depression or suicide attempts
- Diabetes, type _____, how long _____
- Drug or Alcohol abuse
- Ear infections
- Eating disorder, bulimia or anorexia
- Eczema or psoriasis
- Epilepsy (seizures)
- Headaches, type _____
- Head Injury
- Hearing loss or deafness
- Heart problems or murmur
- High blood pressure
- HIV or AIDS
- Hypothyroid or Hyperthyroid
- Inherited disease
- Kidney disease
- Learning disability, type _____
- Lung Disease
- Measles, German Measles or Mumps
- Pneumonia
- Rheumatic or scarlet fever
- Sexually transmitted disease (STD)
- Sickle cell anemia or trait
- Strep throat
- Tuberculosis (TB)
- Whooping cough
- Other _____
- Other _____

Past Surgical and Hospitalization History:

- Appendectomy
- Ear tubes
- Fracture, _____
- Hernia, R or L, type _____
- Psychiatric treatment, inpatient or outpatient
- Tonsillectomy
- Other: _____
- Other: _____

(Turn page over for more questions)

Females Only: Age at first period: _____ yrs. old Date of last period: _____
 Number of: Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
 Birth control method: _____ Date of last Pap smear: _____

Drug allergies: No Known Drug Allergies
 Name of Drug _____ Reaction _____

Current Medications: (prescription, over-the-counter, herbs, vitamins, fluoride):

Medication	Strength/Dose	Frequency	Medication	Strength/Dose	Frequency

Immunizations: Are your child's immunizations up-to-date? Yes No
 If not available today, please provide a copy of your child's immunization record by the next visit.

Social History:

Parents: Married Divorced, if divorced, who does child live with: _____
 How is child doing in school? Good Fair Poor In special classes: Yes No
 Tobacco: Cigarettes Smokeless How much/day _____; how long _____; Quit, when _____
 Alcohol: Number of drinks or bottles of beer per week: _____
 Caffeine: Number of cups of coffee _____/day, glasses of tea _____/day, sodas _____/day
 Sexually active: Yes No New partner in the last year? Yes No
 Victim of Abuse: physical sexual mental verbal Who is / was abuser? _____
 Infant car seat, toddler seat or seat belt restraint used regularly: Yes No, why? _____
 Firearms (guns or rifles) in home: Yes No Under lock and key: Yes No
 Exposure to hazardous materials or lead? _____
 Special diet or vegetarian? _____ Travel to foreign countries? _____
 Death in family in the last year? Yes No Relationship _____
 Cigarette or cigar smokers in the home? Yes No
 Members of household (list): _____

Family History:

	Living		Deceased	
	Age	Health status or illnesses	Age	Cause of death & illnesses
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Father's father	_____	_____	_____	_____
Father's mother	_____	_____	_____	_____
Mother's father	_____	_____	_____	_____
Mother's mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

Parent or Guardian Signature: _____ Date: ____/____/____

Provider review: Signature: _____ Date: ____/____/____