Pediatric Health History

Your child's health is of utmost importance to us. Please fill out this form as accurately as you can. All information will be treated confidentially.

Today's Date: ______/_____/______

Child's Name:

____

Date of Birth: _____/____/______

Previous Physician/Facility:

____

Previous Physician Phone and/or Fax Numbers:

____

Does your child Attend School or Day Care?
Y or N (Please circle one)
Facility Name:

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Is your child on any medications?
Y or N (Please circle one) If so, please list:

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Is your child allergic to any food or medications?
Y or N (Please circle one) If so, please list:

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Has your child had any serious illness or hospitalizations? Y or N (Please circle one) If so, please provide dates and details of event:

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Place an X in the column if your child has had any of the following, or if you wish to discuss.

General Symptoms	X	**Gastrointestinal**	X	**Heart**	X
Chills		Blood in stool		Chest Pain	
Dizziness		Constipation		Irregular Heart beat	
Fainting		Vomiting		Shortness of Breath	
Headache		Reflux (infant vomiting)		Heart Disease: please give	
Weight Gain or Loss		Rectal Bleeding		Details:	
Wheezing		Diarrhea		**Skin**	X
Cough more than 2 wks.		**Urinary**	X	Eczema	
Stomach Pain		Bed-wetting		Rash that won't go away	
Vision Problems		Blood in Urine		Easy to bruise	
Hearing/Speech	X	Long term diaper rash		Hives	
Difficulty Hearing		Pain in vagina or penis		Moles that change	
Hearing Loss		Painful urination		Warts	
Frequent Ear Infections		Unusual urine color		Discoloration	
Speech Difficulty		Discharge from vagina or penis		Boils	
Ear Infections more than two per year		**Musculoskeletal**	X	**Behavior**	X
Respiratory	X	Broken Bones: please list		ADHD	
Asthma		Muscle Sprains: please list		Depression	
Frequent Sinus Infection		Pain in bone or joint, please list:		School Problems	
More than 8 colds/year		Coordination problem		Anxiety	
Nosebleeds		Swollen Joints		Treatment in the past for any Mental Health Illness	
Frequent Runny Nose					
Seasonal Allergies					

Past Family History:
Please provide any information about illnesses that run in your family here:

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Please list any other information here that you feel the doctor should know about your child:

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