THE FAMILY HEALTH CENTER
Pediatric Health History—Newborn to 8 years

Today's Date _____

Patient Name_____ **Date of Birth**_____**Gender M**_____**F**_____

Mother's Name_____ **Father's Name**_____

Relationship to child Birth____ Adoption ____ Stepchild _____ Other _____

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

Allergies (medications, foods, environmental/seasonal):

Immunizations (please provide shot record) Up-to-date? Yes _____ No _____

Pregnancy and Birth

1. Please list any medical problems or complications that occurred during pregnancy:

2. Delivery: preterm_____ term_____ post-term_____ vaginal_____c/section_____

3. Please list any complications that occurred during or after delivery:

Developmental History

1. Please list any concerns about your child's growth or development:

2. Did your child experience any delays in the following (check all that apply)
____rolling over ____babbling/laughing ____reaching out for objects ____sitting without support
____feeding him/herself ____saying "mama", "dada" or other simple words ____drinking from a cup
____sitting alone (without support) ____pulling themselves up to standing position ____standing alone (without support)
____walking ____toilet training for urine ____toilet training for bowel movement ____nighttime control of urine or bowels
____ combine 2 or more words to make sentences

Childhood Illnesses Please check all of the conditions your child has had:

Constitutional
___Fevers/Chills/Excess Sweat
___Unexplained Weight Loss/gain
Eyes
___Vision problems
___Eye pain
___Squinting/Cross-eyed
Ears/Nose Throat
___Hearing problems
___Ear infections
___Tonsillitis
___Frequent runny nose
___Bad breath
___Sore throats
Respiratory
___Cough/Wheezing
___Frequent Bronchitis
___Asthma

Skin
___Rashes
___Birth Marks

Cardiovascular
___Tires easily with exertion
___Shortness of breath
___Fainting
___Heart murmur
Gastrointestinal
___Nausea/Vomiting/Diarrhea
___Constipation
___Blood in bowel movement
___Frequent stomach aches
Genito-urinary
___Bedwetting
___Pain with urination
___Urinary tract infections
___Frequent urination

Neurological
___Knocked unconscious
___Clumsiness
___Headaches
___Seizures

Infectious Diseases
___Mumps
___Measles
___German Measles (Rubella)
___Chicken Pox
___Whooping Cough
___Meningitis
Musculoskeletal
___Broken bones (list)_____
___Balance/Coordination problems
___Muscle pain
___Joint pain
___Leg pain
Blood/Lymph
___Unexplained lumps
___Easy Bruising/Bleeding
Emotional
___Speech problems (poor pronunciation, etc.)
___Problems with sleep/nightmares
___Depression
___Temper tantrums
___Anxiety/Stress

Diet/Nutrition
Is/was your child breastfed? Yes____ No____
If yes, for how long?

How much milk does your child drink daily (8 ounces=1 cup)?
What type of milk? Cow's____ Whole____ 1 or 2%____ Skim____ Soy____ Other_____

How much juice does your child drink daily?

How many soft drinks does your child drink daily?

Did/does your child have any feeding or dietary problems? Yes____ No ____
If yes, please specify

Sleep
How many hours of sleep does your child typically get each night?
Naps (number and length):
Please list any concerns or problems related to sleep, sleep habits:

Dental
Please describe your child's daily routine for oral care, e.g., tooth-brushing

Has your child been seen by a dentist: Yes____ No____
If yes, when was the most recent visit?

Please list any concerns or problems related to dental health:

Vision
Has your child been seen by an eye doctor? Yes____ No____
If yes, what was the reason for the visit?

Please list any concerns about your child's vision:

Exercise/Routines/Exposures
Does your child get daily exercise? Yes____ No____
Is your child involved in any of the following activities (please check all that apply)
Sports ____ If yes, please list
Music ____ Scouting _____
Other Clubs/Groups _____ If yes, please list

How many hours per day of "screen time" (TV, computer, video games) does your child typically get? ____hours/day
Is your child exposed to any of the following:
Tobacco smoke? Yes____ No____ Smoke from wood-burning stoves? Yes____ No____
Are there unsecured guns in the household? Yes____ No____

School
Current School/Daycare

Any concerns about school performance? Yes____ No____
If yes, please explain:

Please use the space below to tell us anything else about your child's health or behavior that your feel is of concern that hasn't been mentioned or asked about yet:

Parent/Guardian signature _____ Date _____

Provider signature _____ Date _____

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