COMMUNITY CARE PEDIATRICS-SARATOGA

PEDIATRIC HEALTH HISTORY FORM

Child's Name		Date			
Child's Previous doctor/ Primary Care Provider		DOB		Age	
Allergies/Reactions:					

PRESENT HEALTH CONCERNS	**MEDICATIONS/VITAMINS**	**HERBS/HOME REMEDIES**

PREGNANCY AND BIRTH	
1.	Is this child your by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:
2.	Please indicate any medical problems during pregnancy: ☐ None ☐ Specify:
3.	Delivered by: ☐ Vaginal Birth ☐ Caesarean If caesarean, why:
4.	Birth Weight: Birth Length:
5.	Please indicate any medical problems during the baby's newborn period: ☐ None If premature, how early?
	Other problems:
NUTRITION AND FEEDING	
1.	Was your child breastfed? ☐ No ☐ Yes If so, how long?
2.	Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, specify:
3.	Milk intake now: Type ☐ Cow milk (☐ non-fat ☐ 1% fat ☐ 2% fat ☐ whole milk) ☐ Soy milk ☐ Rice milk
	Average ounces per day (Note: 8 ounces are in 1 cup):

SLEEP
Hours per night: Naps (number and length):
Any sleep problems: ☐ No ☐ Yes, explain:
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 chickenpox ☐ No ☐ Yes

EXPOSURES/HABITS:	Any concerns about lead exposure (old home/plumbing/peeling paint)? ☐ No ☐ Yes
Do any household members smoke? ☐ No ☐ Yes TV hours per day: Computer hours per day: Video games hours per day?	

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates:
ADDITIONAL HISTORY DISCUSSED: HOSPITALIZATIONS/OPERATIONS/BROKEN BONES/SEVERE SPRAINS (WITH DATES)

FAMILY HISTORY Please check off any family history of the following (indicate who has/had the condition)		
☐ Alcoholism/Drug Abuse	☐ Heart Disease or Stroke before age 60	☐ Inherited/Genetic Diseases
☐ High Blood Pressure	☐ Thyroid Disease	☐ Psychiatric Disorders
☐ Asthma/Hayfever/Eczema	☐ Bleeding/Clotting Problems	☐ Seizures
☐ Kidney Disease	☐ Birth Defects	
SOCIAL HISTORY	Birthplace:	Current (or upcoming) grade:

Who lives at home:			
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:

Are the child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced If divorced, when?

Parent's Occupation: Mother: Father:

Child care situation ☐ Parents ☐ Other (specify who and hours per day):

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 preschool? ☐ No ☐ Yes Current Grade:
Name of school:	Any concerns about school performance?

Any concerns about relationships with: Teachers ☐ No ☐ Yes, explain:
Students ☐ No ☐ Yes, explain:

If over 4 years old, does your child have a best friend? ☐ No ☐ Yes

Sports/exercise: Type: How often? How long (minutes):

REVIEW OF ORGAN SYSTEMS: IF CHILD HAS MORE THAN ONE SYMPTOM IN A LINE, CIRCLE THE RELEVANT ONE(S).

Constitutional/Endocrine ☐ Fevers/chills/excessive sweating ☐ Unexplained weight loss/gain	Gastrointestinal ☐ Nausea/vomiting/diarrhea ☐ Constipation ☐ Blood in bowel movement	Allergy ☐ Hayfever/itchy eyes
Eyes ☐ Squinting/"crossed" eyes/asymmetric gaze	Cardiovascular ☐ Tires easily with exertion ☐ Shortness of breath ☐ Fainting	Skin ☐ Rashes ☐ Unusual moles
Ears/Nose/Throat ☐ Unusually loud voice/hard of hearing ☐ Mouth breathing/snoring ☐ Bad breath ☐ Frequent runny nose ☐ Problems with teeth/gums	Genitourinary ☐ Bedwetting ☐ Pain with urination ☐ Discharge: penis or vagina	Psychiatric ☐ Speech problems ☐ Anxiety/Stress ☐ Problems with sleep/nightmares ☐ Depression ☐ Nail biting/thumbsucking ☐ Bad temper/breath holding/jealousy
Respiratory ☐ Cough/wheeze	Neurological ☐ Headaches ☐ Weakness ☐ Clumsiness	Blood/Lymph ☐ Unexplained lumps ☐ Easy bruising/bleeding
Muscular ☐ Muscle/join pain		

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