

INDIANA ADULT & PEDIATRIC MEDICINE

Pediatric Health History

Child's Name: _____ Birth Date: _____

Mother/ Guardian's Name _____ Occupation: _____

Father/ Guardian's Name _____ Occupation: _____

- What is the reason for this visit? _____

PREGNANCY AND BIRTH

Mother's age at birth: _____ Did mom have problems during pregnancy? _____

Vaginal or C-section delivery? _____ Was the baby on time? _____

What was the baby's birth weight? _____ Did the baby require any special help during delivery? _____

Medications During Pregnancy? _____

Did the baby have problems in the hospital, like jaundice or an infection? _____

PAST MEDICAL HISTORY

Where has your child gone for check-ups until now? _____

Last dental check-up? _____

List allergies to medications or food _____

Any hospitalizations? _____ Injuries or surgeries? _____

LIST regular medications: _____

LIST illness or chronic problems: _____

Has your child had chickenpox? _____ Have any of your children had a bad reaction to a vaccine? _____

FAMILY HISTORY

LIST health problems of biological parents: _____

LIST age, sex, and health conditions of brothers and sisters: _____

CIRCLE any diseases that this child's blood relatives (parents, grandparents, aunts and uncles) have had:

Anemia Asthma Allergies Cancer Diabetes Genetic disease High blood pressure

Tuberculosis(TB) Drug Abuse Alcoholism Suicide Skin Cancer AIDS

List any other illnesses: _____

DIET AND NUTRITION

Is your child's appetite usually good? _____ In the first six months, was the baby bottled or breast fed? _____

Does your family follow any special diets? (vegetarians, Kosher, other)? _____

How many cups of milk does your child drink per day? _____ How many sodas or juice per day? _____

Does he/she take vitamins? _____

DEVELOPMENT / BEHAVIOR

At what age did your child sit alone? _____ At what age did he/she walk alone? _____

Did your child say any words by age 15 months? _____

Does your child have problems with bedtime or sleeping? _____

What grade and school is he/she in? _____

How is your child doing in school? _____

Do you have any concerns about your child's behavior? _____

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DEVELOPMENT / BEHAVIOR (continued)

How does your child compare to others his or her own age? _____

What hobbies or sports is your child involved in? _____

How many hours of TV per day does your child watch? _____

How many hours of video game or computer use? _____

SAFETY / ENVIRONMENT

Do you live in a private house, an apartment, or a mobile home? _____

Who lives in your home? _____

Child Care Arrangements? _____

- My child uses a car seat/ seat belt:
 all the time most of the time sometimes
- Are there any smokers at home? _____
- Any Pets? _____
- Does your child have a bicycle helmet? _____
- Do you have *working* smoke alarms? _____

OTHER COMMENTS

Signature of Parent/Guardian

Date