Pediatric Health History

Date: _____

Patient Name	Date of Birth
Parent's Name	**Gender**

Birth History	
Birth Weight	
Where Born	
Number of Siblings	
Number of weeks at delivery	
Any complications in the pregnancy? If so, please list.	□ yes □ no
Vaginal or Cesarean section (please circle) If Cesarean, please list why.	
Any complications of labor and delivery? If so, please describe.	□ yes □ no
Any newborn complications? If so, please describe.	□ yes □ no

Patient Medical History

Have the patient ever been hospitalized (check one)	□ yes □ no
If so, for what reason (please print)	
Has the patient ever required surgery (check one)	□ yes □ no
If so, for what reason (please print)	
Reoccurring problems (like ear infections, asthma, or anything else that has prompted a need to see the doctor more than twice	

Family Medical History

Please indicate (check box) if any family members have had the following	**List Family members' relationship to patient: i.e. aunt, father, sister**
Heart Disease	
High Blood Pressure	
Diabetes	
Kidney Problems	
Cancer	
Bleeding Disorder	
Developmental Disability	
Congenital (birth) Defects	

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Epilepsy	
Psychiatric problems	
High Cholesterol	
Hereditary Diseases	
Reoccurring Ear Infections	
Substance Abuse	

Medication Allergies and Reactions	
Food Allergies and Reactions	
Pollen/Environmental Allergies and Reactions	
No known allergies	□ (check if applicable)

Please provide a copy of your child's immunization record and please update.

Immunizations	**Date of last**
DPT or DT	
MMR	
Polio	
HIB	
Hepatitis B	
Influenza	
PCV	
Other (please print)	
Please list any worrisome reactions	

Has a lead exposure test been done: If so, please provide date and result	□ yes □ no Date: _____ Result: _____

Social Information

Inquiry	**Response**
Who lives in your child's household?	
If separate from your child's other parent, how are custody and visitation arranged?	
Is your child exposed to tobacco smoke?	At home___ at day care ___ elsewhere___
Is there anyone your child is close to who has a problem with alcohol or other controlled substances?	
Is your child in daycare?	
Are there any particular behavioral problems you are concerned about? (Please describe)	

Any school problems? (Please describe)	
How do you usually discipline your child?	
Are there any concern you would like to discuss with your doctor?	

Medications	**Please list all Medication your child currently uses and the dosages, including herbs, vitamins/supplements, aspirin, antacids, tonics, water pills, laxatives, tranquilizers, nerve pills, social drugs, and to other medication bought with or without a prescription.**	
Name	**Dose**	**How often**

Information updated in eCW: □ Yes □ No