FAMILY FIRST PEDIATRICS

Health History Form

CHILD'S NAME:_____**DOB**_____

AGE: _____

CURRENT HEALTH CONCERNS: _____

_____

Current Medications:

Medication Name	Dosage	Frequency

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS:

Medication or Vaccination Name	What happens with Reaction i.e. Rash, shortness of breath	Site i.e. arm, thigh

PREGNANCY & BIRTH

Is the child yours by: birth adoption stepchild other: _____
Please indicate any medical problems during pregnancy. None
Other:_____
Delivery by: Vaginal birth Caesarian
If caesarian, Why?_____
If premature, Why? _____
Birth Weight _____ Birth Length _____
Please indicate any medical problems during the baby's newborn period. None
Other _____

NUTRITION & FEEDING

Was your child breastfed? No Yes If yes, how long? _____
Has your child had any unusual feeding/dietary problems? No Yes If yes, specify:
_____
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: _____ Nap's (number and length): _____
Any sleep problems?_____

DEVELOPMENT

At what age did your child: sit alone ____ walk alone ____say words ____ toilet train (daytime) _____
Girls only: Age of first menstrual period _____

DENTAL HISTORY

Has your child been seen by a dentist? No Yes If so, how often _____ Date of last visit _____
Has your child had: filling cap/crown bridge braces other orthodontic work _____

Puberty (if applicable)

What age did your child start puberty?_____

Females: Age of first Menstrual Cycle:_____ Regular_____ Irregular_____
Sexually Active_____

Males: Pain or swelling_____ Hernias_____
Sexually Active_____

PAST MEDICAL HISTORY

Has your child had: chicken pox measles mumps rubella meningitis tuberculosis (TB)
~~~~***Please bring a copy of your child's immunization record to your appointment***~~~~~
Please describe any major medical problems and their dates

_____
_____
_____

Hospitalizations / Operations (with dates) _____
_____
_____
_____

Broken Bones or severe strains / sprains (with dates) _____
_____
_____

Major falls, traumas or other injuries (with dates) _____
_____

When was child's last physical exam?_____

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 _____

Students No Yes _____

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

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

	MOTHER	FATHER	BROTHER	SISTER	AUNT	UNCLE	GRAND MOTHER	GRAND FATHER
Alcohlism/Drug								
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FAMILY HISTORY: Check any family history of the following (indicate who has/had the condition)

Review of organs systems: If your child has more then one symptom on a line, circle relevant one(s)

CONSTITUTIONAL / ENDOCRINE
Fever / chills / excessive sweating
Unexplained weight loss / gain

EYES
Squinting / "crossed eyes"

EARS / NOSE / THROAT
Unusually loud voice / hard of hearing
Mouth breathing / snoring
Bad breath
Frequent runny nose
Problems with teeth / gums

RESPIRATORY
Cough / wheeze

GASTROINTESTINAL
Nausea / vomiting / diarrhea
Constipation

GENITOURINARY
Bedwetting
Pain with urination
Discharge: penis or vagina

MUSCULOSKELETAL
Muscle / joint pain

ALLERGY
Hay fever / itchy eyes

SKIN
rashes / unusual moles

PSYCHIATRIC / EMOTIONAL
Speech problems
Anxiety / stress
Problems with sleep / nightmares
Depression
Nail biting / thumb sucking
Bad tember / breath holding
Jealousy

BLOOD / LYMPH
Unexplained lumps
Easy bruising / bleeding

CARDIOVASCULAR
Tires easily with exertion
Shortness of breath
Fainting

NEUROLOGICAL
Headache
Weakness
Clumsiness

The information that I have provided is to the best of my knowledge, true. I authorize Family First Pediatric to speak with or request records from other physicians who, now or in the past, have cared for this child. I authorize the release of correspondence and/or medical records to other medical providers involved in this child's care.

Signature _____ Date _____

Printed Name _____Relationship to child _____