

BETHANY PEDIATRICS LLC
PEDIATRICS AND ADOLESCENT
MEDICINE

NAME: _____

DATE OF BIRTH: _____

AGE: _____

Pediatric Health History Form

Your relationship to child: _____

Child's previous doctor/primary

Care provider: _____

Present health concerns: _____

Medicines/Vitamins:

Herbs/Home Remedies:

Allergies/Reactions to
medicines or vaccinations:

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: Birth Adoption
 Stepchild Other:

Please indicate any medical problems during pregnancy

None Specify: _____

Delivery by Vaginal birth Caesarean

If Caesarean, why? _____

Birth weight: _____ Birth length: _____

APGAR score 1 min. _____ 5 min. _____

Please indicate any medical problems during the baby's
newborn period None (If premature, how early?)

Other problems: _____

NUTRITION & FEEDING

Was your child breastfed? No Yes

If so, how long?

Has your child had any unusual feeding/dietary
problems? No Yes If yes, specify:

Milk intake now: Type Cow's milk (Nonfat
 1% fat 2% fat Whole)
 Soy milk Rice milk

Average ounces per day (Note: 8 ounces = 1 cup)

SLEEP

Hours per night _____

Naps (number & length) _____

Any sleep problems? _____

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 any of the following diseases:

- Chickenpox Measles Mumps
- Rubella Meningitis Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint) No Yes

Do any household members smoke? No Yes

TV - hours per day _____

Computers - hours per day _____

Video games - hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their
dates?

Hospitalization/operations (with dates):

Broken bones or severe sprains:

FAMILY HISTORY

Please indicate any deaths of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____

High cholesterol _____

Cancer, specify type _____

High blood pressure _____

Heart disease _____

Stroke _____

Depression/suicide _____

Bleeding or clotting disorder _____

Genetic disorders _____

Asthma/COPD _____

Diabetes _____

Other: _____

SOCIAL HISTORY

Who lives at home?

Name Age Relationship Highest Education Level

Are your child's parents Married Unmarried

Separated Divorced

If divorced or separated, when? _____

Mother's Occupation _____

Mother's Employer _____

Father's Occupation _____

Father's Employer _____

Child care situation Parents Others (specify who and how often) _____

Concerns about your child: Alcohol use Tobacco

Sexual activity Aggressive behavior

Sign and date :

Is violence at home a concern? No Yes

Are there guns in the home? No Yes

SCHOOL HISTORY

Did/does your child attend school or preschool?

No Yes

Current grade _____

Name of school _____

Any concerns about school performance?

Any concerns about relationship with:

Teachers No Yes

Peers No Yes

If more than 4 years old: does your child have a best friend? No Yes

Sports/exercise: Type _____

How often? _____

How long (minutes)? _____

REVIEW OF SYMPTOMS: Please check any current problems your child has on the list below:

General

- _____ Fevers/chills/excessive sweating
- _____ Unexplained weight loss/gain

Genitourinary

- _____ Bedwetting
- _____ Pain with urination
- _____ Discharge: penis or vagina

Eyes

- _____ Squinting/"crossed" eyes/asymmetric gaze

Musculoskeletal

- _____ Muscle/joint pain

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

Allergy

- _____ Hay fever/itchy eyes

Cardiovascular

- _____ Tires easily with exertion
- _____ Shortness of breath
- _____ Fainting

Neurological

- _____ Headaches
- _____ Weakness
- _____ Clumsiness

Respiratory

- _____ Cough/wheeze
- _____ Chest pain

Psychiatric/Emotional

- _____ Speech problems
- _____ Anxiety/stress
- _____ Sleep issues
- _____ Depression
- _____ Nail biting/thumb sucking
- _____ Bad temper/breath holding/jealousy

Gastrointestinal

- _____ Nausea/vomiting/diarrhea
- _____ Constipation
- _____ Blood in bowel movement

Blood/Lymph

- _____ Unexplained lumps
- _____ Easy bruising/bleeding