SEASHORE PEDIATRICS

Pediatric Health History Form – Initial Visit

CHART #

Child's Name _____ Date of Birth _____ Age _____ Male _____ Female _____

Mother's Name _____ Father's name _____

Form filled out by _____ Date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications _____

Delivery by ☐vaginal ☐c-section

Reason for c-section _____

Complications _____

Was your child premature ☐No ☐Yes, born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease _____
- ☐Wheezing or bronchiolitis _____
- ☐ Seasonal allergies or eczema _____
- ☐ Food allergy _____
- ☐ Recurrent ear infections _____
- ☐ Pneumonia _____
- ☐ Urinary tract infections _____
- ☐ Genetic syndrome _____
- ☐ Seizures _____
- ☐ Anemia _____
- ☐ Broken bone _____
- ☐ Mental retardation or learning disability _____
- ☐ Depression/anxiety _____

Other chronic medical conditions _____

_____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

_____

_____

Previous surgeries and dates _____

_____

Previous pediatrician _____

Please list any specialist your child is currently seeing and reason:

_____

_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

_____

_____

Current medications and dose: _____

_____

_____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Development/Nutrition

At what age did your child:

Walk alone _____ Sit alone _____

Toilet train(day) _____ Say words _____

1st period (females) _____

Was your child breastfed ☐ No ☐Yes, how long? _____

Has your child had any unusual feeding/dietary problems? Explain.

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____

☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Mother's occupation _____

Father's occupation _____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

School's name _____ Grade _____

Any concerns about school performance? ☐ No ☐ Yes, explain

_____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____Computer _____Video games _____

Sports/exercise: Type _____

How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____

_____

_____

_____

Review of Systems (*Check all that apply*)

Constitutional
- ☐ Fever, chills ☐ Fatigue
- ☐ Unexplained weight loss/gain
- ☐ Excessive thirst

Ear, Nose, and Throat
- ☐ Loud voice, hearing problem
- ☐ Mouth-breathing, snoring
- ☐ Ear pain
- ☐ Frequent runny nose

Respiratory
- ☐ Cough, short of breath
- ☐ Chest tightness, wheeze

Musculoskeletal
- ☐ Muscle pain, weakness
- ☐ Joint pain, swelling
- ☐ Bone pain

Other (eye, skin, blood)
- ☐ Blurry vision ☐ Squinting
- ☐ "Crossed" eyes ☐ Itchy eyes
- ☐ Rashes ☐ Abnormal moles
- ☐ Abnormal bruising, bleeding

Gastrointestinal
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation, blood in stool
- ☐ Abdominal pain

Cardiovascular
- ☐ Chest pain, palpitations
- ☐ Tires easily with exertion
- ☐ Fainting

Genitourinary
- ☐ Frequent or painful urination
- ☐ Bedwetting, frequent accidents
- ☐ Vaginal or penile discharge

Neurologic
- ☐ Headaches ☐ Seizures
- ☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
- ☐ Anxiety/stress ☐Depression
- ☐ Sleep problem ☐ Anger concern
- ☐ Concerns with attention, impulsivity

Reviewed by _____ *MD* *date* _____