Patient Health History Form

Pediatric Healthcare, LLC
Montgomery, AL 36106

Chart #:_____
Date: _____

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

Previous doctor and location: _____

Present health concerns: _____

_____

A. Your Child's Birth History:

Mother's age at birth of the child: _____

Were there any complications during the pregnancy? ☐ No ☐ Yes_____

Was the baby on time? ☐ No ☐ Yes Birth Weight: _____lbs. _____oz.

Did the baby have any trouble while in the hospital? ☐ No ☐ Yes_____

B. Past Medical History:

Has your child had allergic reactions to any medications, foods, insect bites? ☐ No ☐ Yes (If yes, please list)

_____

Any reactions to any immunizations? ☐ No ☐ Yes_____

Any hospitalizations? ☐ No ☐ Yes_____

Any serious injuries? ☐ No ☐ Yes_____

Any surgery? ☐ No ☐ Yes_____

C. Family History:

Indicate all blood relatives of your child who have the following problems: (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin.

High cholesterol	☐ No ☐ Yes_____	Depression/mental illness	☐ No ☐ Yes_____
High blood pressure	☐ No ☐ Yes_____	Digestive problems	☐ No ☐ Yes_____
Heart disease before age 55	☐ No ☐ Yes_____	(reflux, ulcers, etc.)	
Diabetes	☐ No ☐ Yes_____	Kidney or bladder problems	☐ No ☐ Yes_____
Alcoholism/drug abuse	☐ No ☐ Yes_____	Seizures or epilepsy	☐ No ☐ Yes_____
Allergies/hay fever	☐ No ☐ Yes_____	Sudden death prior to age 40	☐ No ☐ Yes_____
Asthma	☐ No ☐ Yes_____	Thyroid disease	☐ No ☐ Yes_____
Cancer	☐ No ☐ Yes_____	Tobacco use	☐ No ☐ Yes_____

D. Nutrition:

During the first 6 months of life was your child: ☐ Breast-fed ☐ Bottle-fed

Is your child still on formula? ☐ No ☐ Yes If yes, which formula do you use? _____

Did/Does your child have any feeding or eating difficulties? ☐ No ☐ Yes_____

Has your child ever been placed on a special diet? ☐ No ☐ Yes_____

Do you have any concerns about your child's weight or diet? ☐ No ☐ Yes_____

Is your child taking vitamins? ☐ No ☐ Yes_____

(Please complete both sides)

E. Review of Systems:

Has your child had frequent ear infections? □ No □ Yes_____

Does your child have frequent colds or sore throat? □ No □ Yes_____

Is there asthma, pneumonia, or recurrent cough? □ No □ Yes_____

Does your child have a heart murmur or heart condition? □ No □ Yes_____

Is there a history of convulsions or other nervous system problems? □ No □ Yes_____

Is there a history of eczema, hives, or other skin conditions? □ No □ Yes_____

Please list any other medical problem(s): _____

F. Your Child's Health:

Does your child have any chronic or serious illnesses? □ No □ Yes_____

Has your child missed any immunizations? □ No □ Yes_____

Is your child currently on any medications? □ No □ Yes_____

_____

G. Development and Behavior:

At what age did your child sit alone? _____

At what age did your child walk alone? _____

Did your child speak by 18 months of age? □ No □ Yes_____

Does/Did your child have any delays in development? □ No □ Yes_____

Are there any significant behavioral or disciplinary problems? □ No □ Yes_____

Does your child have any trouble sleeping? □ No □ Yes_____

H. Social History:

Who lives at home?

Name	Age	Relationship

Are the child's parents: □ Married □ Never Married □ Separated □ Divorced □ Remarried

Childcare situation: □ Parents □ Daycare □ Other _____

I. School History:

Does your child attend school or preschool? □ No □ Yes Current Grade: _____

Does your child receive any special services at school? □ No □ Yes_____

Have there been any problems in school? □ No □ Yes_____

Are there any concerns about school performance? □ No □ Yes_____