CARSON FAMILY CARE CENTER
Pediatric Health History Form – Initial Visit

Child's Name_____ Date of Birth_____ Age_____
Your Name_____ Relationship to child _____

Child's Past Medical History

Where was your child born_____
Is the child yours by __birth __adoption __stepchild __ other
Pregnancy complications _____
Delivered by ___C-section ___ vaginal birth
Was your child premature _____
Birth weight _____ Length _____

Infancy/childhood/adolescence

Asthma or reactive airway disease_____
Wheezing, bronchitis, pneumonia_____
Seasonal allergies_____
Food allergies_____
Recurrent ear infections_____
Urinary tract infections_____
Genetic syndromes_____
Seizures_____
Anemia_____
Broken bones_____
Mentally challenged or learning disabilities_____
Depression/anxiety_____
Other chronic medical conditions_____
_____
_____
Has your child ever been hospitalized ___No ___Yes
Explain: _____
Any previous surgeries or procedures ___No ___Yes
Explain: _____
List any other physicians your child is currently seeing and
Reason: _____
_____

Medications

List current medications and dose:
_____
_____
_____

ALLERGIES to medicine/vaccines (list and describe reaction)
_____
_____

Development/Nutrition

At what age your child did: sit alone_____
walk alone_____ say words ____ toilet train _____
1st period (females) age _____
Was your child breast fed_____ how long _____
Has your child had any unusual feeding/dietary problems?
Explain: _____
Is your child's immunizations up to date _____

Signature of guardian:
_____
Date: _____
Signature of physician:
_____
Date: _____

Social History

Number of persons who lives in the household with the child _____ number of siblings _____
Child's __parents __married __unmarried __divorced __other
Does your child go to daycare or is cared for by babysitter, family, friend _____
Do any household members smoke ____ yes ____ no
How many hours per day does your child spend:
watching TV____ Computer ____ Video games ____
Child's school name_____ Grade_____
Any concerns regarding peer or teacher relationships _____
_____
Sports/exercise: type_____
How often? _____ How long _____hours

Family history

Do any family members have any of the following conditions:

Condition	mother	father	sibling	grandparents
Asthma	____	____	____	____
Anemia	____	____	____	____
Blood disorder	____	____	____	____
Cancer	____	____	____	____
Heart problems	____	____	____	____
High blood pressure	____	____	____	____
Stroke	____	____	____	____
Diabetes	____	____	____	____
Thyroid disease	____	____	____	____
Kidney disease	____	____	____	____
Seizure	____	____	____	____
Migraines	____	____	____	____
Depression/anxiety	____	____	____	____
Alcoholism/drugs	____	____	____	____
ADD/ADHD	____	____	____	____

Please explain all positives: _____
_____
_____

Review of Systems (circle all that apply)

Constitutional
fever, chills, fatigue
unexplained weight loss
excessive thirst

Ears, nose & throat
cough, short of breath
mouth-breathing, snoring
ear pain, runny nose

Respiratory
cough, wheezing
chest tightness

Musculoskeletal
Muscle pain, weakness
Joint pain, swelling

Other (eye, skin, blood)
Blurred vision, squinting
Eye drainage
Rashes, abnormal moles

Gastrointestinal
nausea, vomiting, diarrhea
constipation, blood in stool
abdominal pain

Cardiovascular
chest pain, palpitations
tires easily with exertion
fainting

Genitourinary
frequent urination, burning
bedwetting, frequent accidents

Neurologic
headaches, seizures
clumsiness, milestone delay

Psychiatric/emotional
anxiety/stress, depression
sleep problem, anger concern
concerns with attention, impulse