De Baca Family Practice Clinic

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: _____

Delivery by: ☐vaginal ☐C-section Reason for C-section:_____

Complications: _____

Was your child premature? ☐ No ☐ Yes, born at ___ weeks. Complications? _____

Apgar scores: 1 minutes:_____ 5 minutes: _____ Birth Weight:_____ Length:_____

Other problems in the newborn period: _____

If child is less than one year old, please provide us with your discharge papers.

SOCIAL HISTORY

Who lives in the household with the child? ☐ Mom ☐ Dad ☐ Siblings #____ ☐ Grandparents ☐ Other

Child's parents are: ☐Married ☐Unmarried ☐Divorced ☐Other Do any household members smoke: ☐No ☐Yes

Childcare: ☐Parents ☐Relatives ☐Daycare ☐Babysitter/nanny Days per week in childcare (not with parents) _____

How many hours per day does your child spend: Watching TV _____ Computer _____ Video games _____

Child's School Name: _____ Grade: _____

Any concerns about school performance? ☐ No ☐Yes Explain: _____

Any concerns about peer or teacher relationships? ☐No ☐Yes Explain:_____

Sports/exercise: Type: _____ How often? _____ How Long _____ min

INFANCY/CHILDHOOD/ADOLESCENCE

Has your child ever been treated for or diagnosed with:

☐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	☐Depression/Anxiety

☐Mental retardation or learning disability

Other chronic medical conditions _____

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

Previous surgeries and dates:_____

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: sit alone _____ Walk Alone _____ Say words _____

Toilet train _____ 1st period (females) _____

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

Current milk intake: Type_____ Amount _____oz/d

FAMILY HISTORY *Do any first-degree family members or the Childs' siblings have any of the follow conditions*:

☐Asthma	☐Anemia	☐Blood Disorder	☐Cancer	☐Heart attack/disease/congenital heart defects
☐High cholesterol	☐High blood pressure	☐Stroke	☐Diabetes	☐Thyroid Disease
☐Kidney Disease	☐Seizures	☐Migraines	☐Genetic Disorders	
☐Depression/anxiety	☐Alcoholism	☐ADD/ADHD	☐Other _____	