

Pediatric/Adolescent Health History Form

Today's Date _____

Patient's Name _____ Age _____ Sex F/M Date of Birth _____

Address _____

Mother's Name _____ Father's Name _____

Home Phone # _____ Mother/Father's Work # _____

Health Insurance Company _____ Referred by _____

ID# _____ Group # _____

Name of the Insured _____

Billing Address of Health Insurance Co. _____

In Case of Emergency, person to be notified is _____ relationship _____

Address & Phone Number _____

Name of Person Responsible for Payments _____

Please list most important health concerns/problems:

1. _____
2. _____
3. _____

Medications

	Now	Past	Frequency
Aspirin	_____	_____	_____
Tylenol	_____	_____	_____
Antibiotics	_____	_____	_____
Decongestants	_____	_____	_____
Other _____	_____	_____	_____

Supplements

	Now	Past	Frequency
Vitamins	_____	_____	_____
Minerals	_____	_____	_____
Herbs	_____	_____	_____
Acidophilus	_____	_____	_____
Other _____	_____	_____	_____

Allergies

Medications Y/N If yes, what? _____

Food/environment Y/N If yes, what? _____

Childhood Illnesses

___ Chicken Pox	___ Measles	___ Mumps	___ Rubella
___ Scarlet Fever	___ Rheumatic Fever	___ Strep throat	___ Pneumonia
___ Mononucleosis	___ Ear Infections	___ Tonsillitis	___ Asthma
___ Eczema/dermatitis	___ Pinworm	___ Other _____	

Immunizations

___ All ___ Some ___ None

___ Hepatitis ___ Flu Shot ___ Varicella (Chicken Pox) Other _____

List types and any adverse reactions to the vaccination shots:

Prenatal/Birth/Feeding History

1. Mother's health during the pregnancy with this infant/child/adolescent -- please check all that apply
___ Age ___ Bleeding ___ Nausea ___ Preeclampsia ___ Toxemia
___ Trauma/injury ___ Stress ___ High Blood Pressure ___ X-rays Exposure
___ Medications ___ Alcohol Consumption ___ Drugs ___ Smoking ___ Other _____
2. Term: Full _____ Premature _____ Late _____ Birth Weight of Baby _____
3. Was pregnancy/birth: Easy/Difficult? If difficult, explain _____
4. Place of birth: Hospital _____ Home _____ Clinic/Birthing center _____ Other _____
5. Feeding: Breast Fed _____ How long _____
Formula Fed _____ How long _____ Type of formula _____
Was formula made out of cow's milk _____ soy milk _____?
Age solid foods begun? _____ Was food introduced in any particular order? Y/N
Any family history of food allergies? _____
What foods were introduced before age 1? _____

Any known food allergy/intolerance _____
6. Sample daily diet (choose a typical day and include foods and liquids)
Breakfast
Snack
Lunch
Snack
Dinner
Snack

Social History

1. Parents: Married _____ Separated _____ Divorced _____
Mother's occupation _____ Full-time or Part-time
Father's occupation _____ Full-time or Part-time
2. Other guardian: _____ Relationship _____
3. Daycare/preschool/school _____ Where _____
How many hours each day? _____ Days each week? _____
4. Sibling: Name Age Chronic Health Issues
a. _____
b. _____
c. _____
d. _____

Any other health concerns you would like to discuss?

Personal Habits:

Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola
Alcohol Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

Do you exercise regularly? Yes No What type? _____

How long? _____ How often? _____

Past History:

Hospitalizations: _____

Serious Illnesses and Injuries: _____

Date of last physical/annual exam _____ Date of last blood tests: _____

Personal and Family History:

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:

Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list their age(s) _____

Reviewed with patient, signed : _____ Date: _____