



PEDIATRIC & ADOLESCENT MEDICINE

Health History

Patient's Name: _____ Sex: Male Female DOB: _____
 Physician: _____ Today's Date: _____

Only the front side of this form needs to be completed for infants. Both sides of the form should be completed for all other children.

IDENTIFICATION	BIRTH HISTORY
Name of person filling out this form (relationship to child):	Did the child's mother have any illnesses or problems during her pregnancy, labor, or delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Is this child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the baby Premature? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
FAMILY HISTORY	Was the baby delivered by Cesarean section? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Child's Mother's Name	Did the baby have any problem breathing at birth? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Child's Father's Name	Did the baby have jaundice? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Parents are: Married Divorced Remarried Separated Single	Did the baby have a seizure? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Who does child live with? Mother Father Other:	Did the baby have any other problems at birth or in first few weeks of life? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Others in home (name/age/relationship)	Was your baby's discharge delayed for any reason? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1.	Birth Weight of baby _____ lbs. _____ oz.
2.	HAS YOUR CHILD EVER:
3.	Been in a hospital overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No Had surgery/ operation? <input type="checkbox"/> <input type="checkbox"/>
4.	Been seen in an emergency room? <input type="checkbox"/> <input type="checkbox"/> Seen a medical specialist? <input type="checkbox"/> <input type="checkbox"/>
Who cares for the child during the day or after school?	Had an allergic reaction to medicine? <input type="checkbox"/> <input type="checkbox"/> Had an allergic reaction to food? <input type="checkbox"/> <input type="checkbox"/>

HAVE ANY FAMILY MEMBERS HAD THESE CONDITIONS? (siblings, parents, grandparents, aunts, uncles)	
Birth defect/ deformity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
Mental illness/ retardation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Peptic Ulcer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Convulsions/ seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney Problem <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Family or inherited diseases <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bleeding disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Serious or fatal childhood illness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sickle cell disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Eye or hearing problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Asthma, allergies, eczema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Immune disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Accidental poisoning <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Diabetes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Smoke regularly <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thyroid Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Drinking problem <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack under age 50 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Drug problem <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart disease at birth <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other health problem: _____

