PREMIER FAMILY PHYSICIANS

Patient Name:_____

DOB:_____

Date:_____

Pediatric Health History Form

Allergies: (Include Drug, Reaction, and Age of Onset):

*please note if allergies were tested by blood or skin testing

Medication/Drug Allergies (list type of reaction) _____

Food Allergies (Do you carry a current epipen?) _____

Seasonal Allergies: _____

Current Problems:

_____

_____

History:

Birth History:

Age of Mom:_____ Birth Weight: _____
Discharge Weight: _____ Gestational Age at Birth (weeks): _____ Delivery Method: Vaginal C-Section
Duration of Labor: _____ If C-Section why?_____

Complications during pregnancy (diabetes, infections, high blood pressure, breech presentation) _____

Alcohol/Drug/Cigarette/Medications during pregnancy_____

Problems with baby in the nursery?_____

Did baby go home with mom?_____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____
Infant Feeding : Breast Bottle Both Formula Name? _____

Comments: Newborn Hearing Screening: Pass Fail , Other Comments: _____

_____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD_____	Yes	No
Anemia _____	Yes	No
Congenital Heart Disease_____	Yes	No
Developmental delay _____	Yes	No
Eczema _____	Yes	No
GE Reflux _____	Yes	No
Murmur _____	Yes	No
Recurrent Otitis (ear infections) ___	Yes	No
Seizures _____	Yes	No
UTI _____	Yes	No
Vesicoureteral Reflux _____	Yes	No
Autism/Asperger's Disorder_____	Yes	No
Learning Problems_____	Yes	No
Chronic abdominal pain_____	Yes	No

Allergic Rhinitis _____	Yes	No
Asthma _____	Yes	No
Constipation _____	Yes	No
Diabetes _____	Yes	No
Mental Illness _____	Yes	No
Recurrent Strep Throat _____	Yes	No
Vision Problems _____	Yes	No
Wheezing/ RSV/Bronchiolitis _____	Yes	No
	Yes	No
	Yes	No
	Yes	No
Concussion_____	Yes	No
Failure to thrive/poor growth_____	Yes	No
Headache_____	Yes	No

*Please list any specialists who your child sees and reason if not listed above*_____

_____

Other Medical History:

_____

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Surgical History: Check Appropriate Box	Yes	No	Date	Surgeon
Adenoidectomy (adenoids removal)				
Appendectomy (appendix removal)				
Ear Tubes				
Heart Surgery				
Hernia Repair				
Orthopedic Surgery				
Tonsillectomy				
Urologic Surgery				

*Other Surgical History:*_____

Please list any hospitalizations and approximate date if not listed above _____

Any previous adverse reaction to vaccines? _____

Immunizations up to date? _____

Please list current prescriptions and over the counter medication and dosage _____

List below any of child's relatives (mother, father, siblings, grandparents, aunts, uncles) who have had the following illnesses.

CONDITION	NO	YES	FAMILY MEMBER
Allergies			
Anemia			
Arthritis			
Asthma, Emphysema, T.B.			
Birth Defects			
Blood Disease			
Bone/Muscle Disease			
Cancer (specify)			
Cystic Fibrosis			
Diabetes ( ) Adult ( ) Juvenile			
Drug / Alcohol Abuse			
Eye / Ear Disorders			
Heart Disease			
High Blood Pressure			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disease			
Nerve Disorder (Epilepsy, C.P.)			
Rheumatic Fever			
Sickle Cell Trait / Disease			
TB or Exposure			
Thyroid Disease			
Autoimmune Disease			
Skin Disease (eczema, psoriasis)			
Heart Attack < 50 years old			