



## 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	Allergic Rhinitis _____	Yes	No
Anemia _____	Yes	No	Asthma _____	Yes	No
Congenital Heart Disease _____	Yes	No	Constipation _____	Yes	No
Developmental delay _____	Yes	No	Diabetes _____	Yes	No
Eczema _____	Yes	No	Mental Illness _____	Yes	No
GE Reflux _____	Yes	No	Recurrent Strep Throat _____	Yes	No
Murmur _____	Yes	No	Vision Problems _____	Yes	No
Recurrent Otitis (ear infections) _____	Yes	No	Wheezing/ RSV/Bronchiolitis _____	Yes	No
Seizures _____	Yes	No		Yes	No
UTI _____	Yes	No		Yes	No
Vesicoureteral Reflux _____	Yes	No		Yes	No
Autism/Asperger's Disorder _____	Yes	No	Concussion _____	Yes	No
Learning Problems _____	Yes	No	Failure to thrive/poor growth _____	Yes	No
Chronic abdominal pain _____	Yes	No	Headache _____	Yes	No

Please list any specialists who your child sees and reason if not listed above \_\_\_\_\_

Other Medical History: \_\_\_\_\_



# PREMIER FAMILY PHYSICIANS

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

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			