

Pediatric Health History

2. Please list the age, sex and health of parents, brothers and sisters:

Development and Medical History:

1. At what age did your child:

Smile ____ Laugh ____ Roll Over ____ Crawl ____ Sit alone ____ Walk alone ____ Say his/her first word ____

- | | <u>Yes</u> | <u>No</u> |
|---|--------------------------|--------------------------|
| 2. Does your child appear to have any trouble hearing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does your child appear to have any trouble seeing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child have difficulty sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child have any problems with his/her teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has your child had three or more ear infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child have more than three colds or sore throats a year with a fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your child have trouble going to the bathroom? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has your child ever had a convulsion or seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has your child ever had hives or eczema? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has your child ever had any wheezing or asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has your child ever had any allergies or reactions to any medications or food? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Please circle any of the following your child has had: Chicken Pox Red or "Hard" Measles German or "3 Day"
Measles Pneumonia Meningitis Cellulitis Colitis Chronic Conditions | | |
| 14. Immunizations up to date: Yes No | | |
| 15. Please check and describe all of the following that apply to your child: | | |

- Broken Bones _____
- Serious Accidents _____
- Operations _____
- Hospitalizations _____
- Serious or Chronic Illnesses/Conditions _____

Social History:

- | | <u>Yes</u> | <u>No</u> |
|--|--------------------------|--------------------------|
| 1. Is your child in day care:
If yes, what type (Center, private, etc)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you separated, divorced or widowed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have there been any recent severe illnesses or death of family members, close friends or peers? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child smoke? (12 years and older) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do the adults in the home smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is your child involved in social activities outside the home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is the amount of television your child watches monitored? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your child participate in physical activity such as playing outside, sports, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has your child been educated in school or at home about drugs, sex and other health topics? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your child talk openly about what is happening at school? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are there rules at home in relation to food, movies, toys, language and makeup? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any concerns not listed previously? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list:

_____ | | |

Parent/Legal Guardian Signature

Date