Suffolk Pediatric Associates, P.C.

Pediatric Health History Form

Child's Name_____ Date of Birth_____Age_____
Your Name_____ Relationship to child _____

Child's Past Medical History

Where was your child born_____
Is the child yours by __birth __adoption__stepchild __other
Pregnancy complications_____
Delivered by____C-section____vaginal birth
Was your child premature? _____
Birth weight_____Length _____

Infancy/childhood/adolescence

Asthma or reactive airway disease_____
wheezing, bronchitis, pneumonia_____
Seasonal allergies_____
Food allergies_____
Recurrent ear infections_____
Urinary tract infections_____
Genetic syndromes_____
Seizures_____
Anemia_____
Broken bones_____
mentally challenged or learning disabilities_____
Depression/anxiety_____
other chronic medical conditions_____
_____
_____

Has your child ever been hospitalized____No____Yes
Explain:_____
Any previous surgeries or procedures____No____Yes
Explain:_____
List any other physicians your child is currently seeing and
Reason: _____
_____

Medications

List current medications and dose:
_____
_____
_____

ALLERGIES to medicine/vaccines (list and describe reaction)
_____
_____

Development/Nutrition

At what age your child did: sit alone_____
Walk alone_____ Say words_____toilet train _____
1st period (females) age _____
Was your child breast fed_____how long? _____
Has your child had any unusual feeding/dietary problems?
Explain: _____

Are your child's immunizations up to date _____

Social History

Number of persons who lives in the household with the child_____number of siblings _____
Child's __parents __married __unmarried __divorced __other
Does your child go to daycare or is cared for by babysitter, Family, friend _____
Do any household members smoke_____yes_____no
How many hours per day does your child spend:
Watching TV_____Computer_____Video games _____
Child's school name_____Grade_____
any concerns regarding peer or teacher relationships _____
_____
Sports/exercise: type_____
_____how often?_____How long_
_____hours

Family history

Do any family members have any of the following conditions:

Condition	mother	father	sibling	grandparents
Asthma	____	____	____	____
Anemia				
Blood disorder	____	____	____	____
Cancer				
Heart problems	____	____	____	____
High blood pressure	____	____	____	____
Stroke	____	____	____	____
Diabetes	____	____	____	____
Thyroid disease	____	____	____	____
Kidney disease	____	____	____	____
Seizure	____	____	____	____
Migraines	____	____	____	____
Depression/anxiety	____	____	____	____
Alcoholism/drugs	____	____	____	____
ADD/ADHD	____	____	____	____

Please explain all positives: _____
_____
_____

Family Profile

Parents – Married/Separated/Divorced

Parent #1

Age? _____ Highest school grade? _____ Health? _____

Parent #2

Age? _____ Highest school grade? _____ Health? _____

_____

Signature of Parent/Guardian ***Date***