

**Pediatric Health History Form  
Newborn – 5 years of age**

Name	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	Today's Date
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**PRENATAL & BIRTH HISTORY:**

Did child's mother receive prenatal care?  No  Yes  
 If yes: What month of pregnancy did prenatal care start? \_\_\_\_\_  
 Did child's mother use alcohol, tobacco or any illegal drugs during pregnancy?  No  Yes  
 If yes: Please list type, amount and frequency \_\_\_\_\_  
 Where was child born? \_\_\_\_\_  
 Please indicate any medical problems during pregnancy  None  Specify: \_\_\_\_\_  
 Delivery by  Vaginal birth  Caesarean If Caesarean, why? \_\_\_\_\_  
 Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_ APGAR score 1 min. \_\_\_\_\_ 5 min. \_\_\_\_\_  
 List any complications at birth (if premature, how early?) \_\_\_\_\_

**CHILD'S ALLERGIES/REACTIONS to food, medicines or vaccinations:**

\_\_\_\_\_

**CHILD'S MEDICAL HISTORY:**

**Major Medical Problems:**  No  Yes, (list, with dates) \_\_\_\_\_  
 \_\_\_\_\_

**Hospitalizations/Operations:**  No  Yes, (list, with dates) \_\_\_\_\_  
 \_\_\_\_\_

**NUTRITION HISTORY:**

Was child breastfed?  No  Yes If yes, for how long \_\_\_\_\_  
 Has child had any unusual feeding/dietary problems?  No  Yes If yes, specify \_\_\_\_\_  
 Milk intake now: Type  Cow's milk ( Non fat  1%  2%  Whole)  Soy milk  Rice milk  
 Average ounces per day (Note: 8 ounces = 1 cup) \_\_\_\_\_  
 Is child a good eater?  No  Yes  
 Does child eat junk food frequently?  No  Yes

**DEVELOPMENT HISTORY:**

**At what age did your child accomplish the following milestones?**

Rolled over \_\_\_\_\_ Sat alone \_\_\_\_\_ Walked alone \_\_\_\_\_ Said words \_\_\_\_\_ Said sentences \_\_\_\_\_ Fed self \_\_\_\_\_  
 Toilet trained (daytime) \_\_\_\_\_

**IMMUNIZATIONS:**

Hepatitis B \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ DtaP \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Influenza \_\_\_\_\_  
 Hib \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Polio \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Rotavirus \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 Pneumococcal \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ MMR \_\_\_\_\_, \_\_\_\_\_ Varicella \_\_\_\_\_, \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_, \_\_\_\_\_

**DENTAL HISTORY:**

Has child been seen by a dentist?  No  Yes If yes, how often? \_\_\_\_\_ Date of last visit? \_\_\_\_\_

**FAMILY HISTORY:** Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions, if deceased due to a condition please put age at death:

Heart Disease \_\_\_\_\_ High Blood Pressure \_\_\_\_\_  
High Cholesterol \_\_\_\_\_ Stroke \_\_\_\_\_  
Cancer, specify type \_\_\_\_\_ Genetic Disorders \_\_\_\_\_  
Diabetes \_\_\_\_\_ Asthma/COPD \_\_\_\_\_  
Sudden infant death (SIDS) \_\_\_\_\_ Alcoholism/Drug overdose \_\_\_\_\_  
Other: \_\_\_\_\_

**SOCIAL HISTORY:**

**Who lives at home?**

Name	Age	Relationship	Name	Age	Relationship

Are the child's parents  Married  Unmarried  Divorced  Separated  
Child care situation  Parents  Other (specify who and how often) \_\_\_\_\_  
Is violence/abuse at home a concern?  No  Yes

**Safety:**

Does infant go on his/her back to sleep?  No  Yes  
Are all objects removed from crib when infant is sleeping?  No  Yes  
Does child wear a bike helmet?  No  Yes  
Does child use seatbelts/car seat consistently?  No  Yes  
Do you have firearms at home?  No  Yes  
Does your house have a working smoke detector?  No  Yes  
Are safety gates used in the home to prevent fall or injury?  No  Yes  
Are household chemicals/cleaning products in locked cabinets?  No  Yes

**Exposure/Habits:**

Any concerns about lead exposure?  No  Yes  
Do any household members smoke?  No  Yes  
TV – hours per day watched by child \_\_\_\_\_

Parent Signature \_\_\_\_\_ Reviewed by \_\_\_\_\_  
Date \_\_\_\_\_