

**Pediatric Health History Form
6 – 10 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: _____
 List any complications at birth (if premature, how early?) _____

ALLERGIES/REACTIONS to food, medicines or vaccinations:

CURRENT MEDICATIONS (name, strength, frequency):

CHILD'S MEDICAL HISTORY:

Major Medical Problems: No Yes, (list, with dates) _____

Hospitalizations/Operations: No Yes, (list, with dates) _____

Broken bones/Severe Injuries: No Yes, (list, with dates) _____

NUTRITION HISTORY:

Has child had any unusual feeding/dietary problems? No Yes If yes, specify _____
 How many servings of fruit does child eat a day? _____ Vegetables? _____ Meat? _____ Dairy? _____
 Does child drink soda/pop? No Yes If yes, how much per day? _____
 Does child drink juice? No Yes If yes, how much per day? _____
 Is child a good eater? No Yes
 Does child eat junk food frequently? No Yes

DEVELOPMENT/BEHAVIORAL HISTORY:

Does child have any problems sleeping? No Yes If yes, explain _____
 Hours of sleep per night? _____ Does child have any problems with bedwetting? No Yes
 Current grade in school _____ Any concerns about school performance? _____
 Any concerns about relationship with:
 Teachers No Yes Peers No Yes If yes, explain _____
 Does child have any behavioral problems? No Yes If yes, explain _____

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? _____

VISION HISTORY:

Has child had a vision screening done? No Yes If yes, when? _____ Does child wear glasses? No Yes

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 _____
Anemia _____ 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 child use a helmet and protective gear for bike riding, skateboarding, skating, etc? No Yes

Does child use booster seat/seat belts consistently? No Yes

Do you have firearms at home? No Yes

Does your house have a working smoke detector? 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 _____

Computer – hours per day used by child _____

Video games – hours per day played by child _____

Parent Signature _____ Reviewed by _____

Date _____