Community Health Center
of the North Country

PEDIATRIC HEALTH HISTORY FORM

Patient Name: _____ Date of Birth: _____

Parent/Guardian Names: _____ Date: _____

CHILD'S BIRTH HISTORY:

Please circle and fill in where needed

During your pregnancy with this child, did you:

Have high blood pressure?	☐ Yes	☐ No
Have Diabetes or sugar in your urine?	☐ Yes	☐ No
Have a urine or kidney infection?	☐ Yes	☐ No
Have any other infections?	☐ Yes	☐ No
Have a venereal disease such as gonorrhea or syphilis?	☐ Yes	☐ No
Take any medications, drugs or alcohol?	☐ Yes	☐ No
Have any problems with labor or delivery?	☐ Yes	☐ No
Was the pregnancy planned?	☐ Yes	☐ No
How long was the pregnancy?		
How much did the baby weigh?	lbs.	oz.
Did the child have any problems after birth? If yes, what:	☐ Yes	☐ No
Did the mother and child come home from the hospital together?	☐ Yes	☐ No
How many days did the mother and child stay in the hospital?	M:	C:
In which hospital was your child born:		

CHILD'S SOCIAL HISTORY:

Please circle and fill in where needed

Child lives with: ☐ **Mother** ☐ **Father** ☐ **Both Parents** ☐ **Other Relatives** ☐ **Foster Parents**

Who lives with this child?

Name:	Relationship to the Child:	Date of Birth:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Does the child spend time regularly with a babysitter?	☐ Yes	☐ No
If yes, how many times per week?		
Does the child spend time at a daycare center?	☐ Yes	☐ No
If yes, how many times per week?		
How many hours per day?		

→

CHILD'S FAMILY HISTORY:

Please circle and fill in where needed

	Father	Mother	Father's Family	Mother's Family	Brothers	Sisters
Asthma						
Diabetes						
Heart Attack at less than 50 Years Old						
Seizures						
Sickel Cell Disease						

CHILD'S MEDICAL HISTORY:

Please circle and fill in where needed

Is your child currently taking any medications? ☐ **Yes** ☐ **No**
If yes, please list:

Does your child have any known drug allergies? ☐ **Yes** ☐ **No**
If yes, please list:

Does your child have any food/environmental allergies? ☐ **Yes** ☐ **No**
If yes, please list:

Has your child ever stayed overnight in the hospital? ☐ **Yes** ☐ **No**
(Please use the back of this page to explain, if needed)

Year	Hospital	Why
1.		
2.		
3.		

Has your child ever had:

Eczema (Allergic Skin Rash)	☐ Yes	☐ No
Chickenpox	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Seizures, Convulsions, Fits	☐ Yes	☐ No

Has your child:

Had any problems seeing or with eyes?	☐ Yes	☐ No
Had any problems hearing or with ears?	☐ Yes	☐ No
Had frequent ear infections?	☐ Yes	☐ No
Had any problems with the heart?	☐ Yes	☐ No
Had any problems with stomach or bowels?	☐ Yes	☐ No
Had any broken or fractured bones?	☐ Yes	☐ No
Had any problems urinating?	☐ Yes	☐ No
Ever eaten paint, clay, or plaster?	☐ Yes	☐ No
Do you give your child vitamins, iron, or fluoride? If yes, what?	☐ Yes	☐ No

Child's Development:
Has your child done things (for example: started sitting, walking, talking) at the same time as his or her brothers, sisters, relatives or friends?

☐ **Yes** ☐ **No**

If no, explain:

Child's School History:
If your child is old enough to go to school, where does he/she go? _____ What Grade? ____

Has your child ever failed a grade?	☐ Yes	☐ No
Attended a special class?	☐ Yes	☐ No
Had behavior problems in school?	☐ Yes	☐ No

If yes to any of the above questions, please explain:

Child's Behavior:

Has your child had frequent nightmares?	☐ Yes	☐ No
Had problems being overly shy?	☐ Yes	☐ No
Been overly clinging to parents or friends?	☐ Yes	☐ No
Been upset lately?	☐ Yes	☐ No
Been overly nervous?	☐ Yes	☐ No
Been unreasonably jealous?	☐ Yes	☐ No
Does your child lie a lot?	☐ Yes	☐ No
Does your child fight a lot?	☐ Yes	☐ No
Does your child steal?	☐ Yes	☐ No

How would you describe your child and his/her behavior?

Additional Information: