Community Health Center
of the North Country

# PEDIATRIC HEALTH HISTORY FORM

Patients Name: _____ DOB: _____

Parents/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? | Yes | No |
| How much did the baby weigh? | Lbs | Oz |
| Did the child have any problems after birth?<br>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 medication?** **Yes** **No**

If yes, please list:

**Does your child have any 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 if needed to explain)

| Year: | Hospital: | Why: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

**Has your child ever had:**

| | | |
|---|---|---|
| Eczema (Allergic skin rash)? | Yes | No |
| Chicken Pox? | Yes | No |
| Anemia? | Yes | No |
| Asthma? | Yes | No |
| Rheumatic Fever? | Yes | No |
| Seizures, convulsions, fits? | Yes | No |

**Has your child:**

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

**Child's Development:**

Has the 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:**