Pediatric History&Physical Patient Name_____ DOB_____

Dear Parent this is a health questionnaire on your child. Please complete this form.

Child's name:	Date of birth:
Contact information for Parent/Foster/Guardian 1	
Name:	Main Phone:
Home Address:	Alt Phone:
Contact information for Parent/Foster/Guardian 2	
Name:	Main Phone:
Home Address:	Alt Phone:
Child lives with? ☐Both P/F/G **1** & **2** ☐P/F/G **1** Mainly ☐ P/F/G **2** Mainly ☐Other:	

Family History

Parent 1.	Age:	Current Health:		
Past Health problems:				
Race/Ethnicity:				
Parent 2.	Age:	Current Health:		
Past Health problems:				
Race/Ethnicity:				
Is there Tobacco use in/around your home? ☐ Yes ☐ No			Working smoke detectors? ☐ Yes ☐ No	
Carbon monoxide Detectors? ☐ Yes ☐ No		Any Firearms? ☐ Yes ☐ No	Lead paint? ☐ Yes ☐ No	
Other children living in your house hold				
Name	Gender	Date of birth	Health issues?	

This next section will be questions about your child's family history if child is a adopted or foster child and you do not know the following information please fill as best you can and mark this box ☐ Foster/Adop

Is there a history in the **family/Blood relative** of: *if yes, state relationship to child*

Allergies	☐ Yes ☐ No		Anxiety	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No		Depression	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Heart attack	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No		Hepatitis	☐ Yes ☐ No	
Birthdefects/Genetic problems	☐ Yes ☐ No		Hearing loss	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No		High Cholesterol	☐ Yes ☐ No	
Learning Disability	☐ Yes ☐ No		Mental Illness	☐ Yes ☐ No	
Seizures	☐ Yes ☐ No		Thyroid problems	☐ Yes ☐ No	
Tuberculosis	☐ Yes ☐ No		Cancer	☐ Yes ☐ No	

Developmental History

At what age did child:	**Age:**	Walk	
Hold up head		Talk	
Roll over		Toilet Train	
Sit unsupported		Feed him/Herself	
Stand alone		Dress him/Herself	

Pediatric History&Physical Patient Name_____ DOB_____

Prenatal/Birth history

While Pregnant, did mother have:		Was labor helped by medication?	☐ Yes ☐ No
Bleeding/spotting	☐ Yes ☐ No	Was labor induced	☐ Yes ☐ No
Gestational diabetes	☐ Yes ☐ No	Was a fertility drug used	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	If yes what kind?	
Kidney disease	☐ Yes ☐ No	Was child born early? Less than 38wks	☐ Yes ☐ No
Premature labor	☐ Yes ☐ No	Was child born late? After 42wks	☐ Yes ☐ No
Threatened miscarriage	☐ Yes ☐ No	Child's Birth weight	
Toxemia	☐ Yes ☐ No	Apgar score (if known)	
Where Was child Born?		Delivery: ☐ Vaginal ☐ C-Section (reason):	
Duration of labor?		Birth Weight: oz Birth Length:	

During hospital stay did child have any of the following:			
Antibiotic treatment	☐ Yes ☐ No	Blue spells	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Skin Rash	☐ Yes ☐ No	Did child stay longer than mother?	☐ Yes ☐ No
How was/is baby fed?	☐ Bottle ☐ Breast	If yes,Why?	

Please give us a copy of previous Immunizations/Vaccines and TB (Tuberculosis) testing or BCG Vaccination

Medical History

Has your child lived or spent time with anyone who was positive for tuberculosis?	☐ Yes ☐ No
Has anyone in your household com to the United States from another country?	☐ Yes ☐ No
Has your child lived or spent time with any who has AIDS or HIV?	☐ Yes ☐ No
Has your child lived or spent time with adults who used intravenous or street drugs?	☐ Yes ☐ No

If your child has had a positive skin test in the past, inform your child's healthcare provider. Your child will not need another test.

Has your child been diagnosed with a condition previously or if you have any specific concerns you wish the doctor to know about please list

_____

_____

Medication List *please include any over the counter medications, vitamins, and supplements*
☐ **Check box if NO Medications**

Drug name	Dosage Strength	How Many times a Day

Allergies ☐ **Check box if NO Allergies**

Drug Name/Drug Class/Food	Reaction
1	
2	
3	
4	

Provider Signature_____ **Date**_____