Pediatric Health History: Please answer these questions as if you were the child.

Date: ___________________

Child's Full Name: __________________________________ **DOB:** ________________
Mother's Full Name: __________________________________ **DOB:** ________________
Father's Full Name: __________________________________ **DOB:** ________________

Brother and Sister Names:	Age:	Brother and Sister Names:	Age:
______________________	____	______________________	____
______________________	____	______________________	____
______________________	____	______________________	____
______________________	____	______________________	____

Family History:
Mark which relative(s) have had the following Health problems using letters below:
M- mother **F**-father **S**-sister **B**-brother **O**-other

___Anemia
___Bleeding disorder
___Asthma
___Chronic Lung Disease
___Tuberculosis
___High Blood Pressure
___Convulsions/fits
___Thyroid problems
___Diabetes
___Stroke
___Ulcers
___Migraines
___Obesity
___Arthritis
___Suicide

Cancer:
___Breast
___Colon
___Melanoma
___Other

Abuse:
___Alcohol/Drug
___Physical
___Sexual
___Spouse
___Other

Immediate Family:
How is their health? For any problems, please give details.

Member	**Age**	**Description**
Father:	____	____________________
Mother:	____	____________________
Sisters:	____	____________________
	____	____________________
	____	____________________
Brothers:	____	____________________
	____	____________________
	____	____________________
Grand-Parents:	____	____________________
	____	____________________
	____	____________________
	____	____________________
	____	____________________
Others:	____	____________________
	____	____________________

Please circle Y= yes or N= no for the following questions:

Tobacco: Any smokers in the home? **Y N** Anyone smoke in the car? **Y N**
Infant Seats: Have? **Y N** Weight limit for seat known? **Y N** ________ limit if known
Seat Belts: Do children under 12 sit in the back seats with seat belts or booster seats? **Y N**
Smoke Alarms: Have? **Y N** Working? **Y N**
Any guns at home: **Y N** Loaded: **Y N** Kept Locked: **Y N** Within child's reach: **Y N**

Newborn Health Information:
Baby's birth weight: _____lbs _____ozs Baby's Length ____ Inches_____ Hours in labor ______
Term Delivery (37 weeks or more) **Y N** If no # of week's pregnant ___________
Type of Delivery: _____Vaginal _____C-Section _____ Forceps _____Vacuum Extractor (suction cup)
Please describe any labor/delivery problems: ____
____
Any procedures or surgeries on child: **Y N** If yes, please list: ______________________________
____
Describe any problems or concerns regarding your child: ______________________________
____