PRIMARY HEALTH SOLUTIONS
PEDIATRIC HISTORY FORM Birth to 12 years of age

IF YOU HAVE DIFFICULTY FILLING THIS FORM OUT OR
HAVE QUESTIONS ABOUT IT, PLEASE TELL THE NURSE.

Child's Name: ___________________________ Birthdate: Month___________Day____ Year__________

Today's Date _____________________ How did you learn about us?_______________________________

Name of person filling out form: _______________________________Relationship to child: ____________

Family History:
Does anyone in the mother's or the father's family have any of the following problems?
Please check YES or NO

	YES	NO	WHO?		YES	NO	WHO?
Alcohol or drug problem				Asthma			
Diabetes				Heart attack before age 50			
High blood pressure				High cholesterol			
Lead poisoning				Seizure or epilepsy			
Sickle Cell problems				Mental illness			
Is there any other serious physical problem, mental problem or disease in the child's family?							

Family Health:

Immediate Family	Name	Age	Living with child		Health (Living, Sick, Deceased)
			Yes	No	
Mother of Child					
Father of Child					
Brothers & Sisters					

Birth history of child:

How many times did the mother see the doctor for prenatal care? 1 2 3 4 5+

Were there any problems with the pregnancy, delivery, or labor?

Did the child's mother smoke during pregnancy?

Did the child's mother drink alcohol during pregnancy?

Did the child's mother take drugs during pregnancy?

Did the child's mother have any infections that needed treatment?

Was the child's mother on medications during pregnancy?

What hospital was the child born at? How many days in the hospital 1 2 3 4+

What was the child's weight at birth?

Was or is the child breast fed or bottle fed?

PEDIATRIC HISTORY FORM CONTINUED

Child's Medical History: Please circle Yes or No

Is the child allergic to medicine or anything else? Yes No

If yes, allergic to what?________________________________

Does the child take any medicines? Yes No

If yes, what medicine?________________________________

Has the child ever been in the hospital overnight? Yes No

If yes, when and why?________________________________

Has the child had any surgery? Yes No

If yes, when and what type of surgery?________________________________

Does the child have a hearing or speech problem? Yes No

If yes, what type of problem?________________________________

Does the child have a vision problem? Yes No

If yes, what type of problem?________________________________

Has the child had problems with or been treated for: Please check YES or NO

	YES	NO		YES	NO		YES	NO
Anemia			Hay fever			Seizures		
Asthma			Heart			Skin		
Bowel Problems			Kidney Problems			Stomach		
Breathing			Lead Problems			Other		
Chickenpox			Muscles					

Does the child have any other problems that you would like to discuss?

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Family Experience: List other adults or children that live in the house with the child, other than the immediate family, and their relationship to the child:

Other household member	Relationship to the child

Was the house or apartment the child lives in built before 1970?________________

Are the child's parents divorced or not living together? Yes No

If yes, what are the custody arrangements for the child?________________

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Who has the main responsibility for taking care of the child?________________

Does the child go to daycare or a babysitter? Yes No

Does the child go to preschool or Head Start? Yes No

If the child is in school, how does he/she do in school?________________________________

Does anyone who lives in the house with the child smoke? Yes No

If yes, who smokes? ________________________________

Has the child ever been abused physically or sexually? Yes No

Has the child ever seen someone physically or sexually abused? Yes No

Is there a gun in the home? Yes No

For office use: Reviewed by: (Provider Signature) Date: