RENTON PEDIATRIC ASSOCIATES Date: _______________

PEDIATRIC HEALTH HISTORY FORM

CHILD'S NAME: ___________________________________ DATE OF BIRTH:_____________________ AGE:___________
CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: ____
PRESENT HEALTH CONCERNS: ____

____
MEDICINES/VITAMINS: ____
HERBS/HOME REMEDIES: ____
ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: ____

____

PREGNANCY & BIRTH

Where was your child born? ____

Is the child yours by: ☐Birth ☐Adoption ☐Stepchild ☐Other: ____________________

Please indicate any medical problems during pregnancy ☐None ☐Specify: __________________________

____

Delivered by ☐ Vaginal Birth ☐Caesarean If Caesarean, why? ____

Birth weight: ______________ Birth length: ______________ APGAR score 1 min ______ 5 min _______

Please indicate any medical problems during the baby's newborn period ☐ None If premature, how early: ______________

Other problems: ____

NUTRITION & FEEDING

Was your child breastfed? ☐No ☐Yes If so, how long? ______________________________

Has your child had any unusual feeding/dietary problems? ☐No ☐Yes If yes, specify: ______________________

____

Milk intake now: Type ☐Cow's milk (☐ Nonfat ☐1% fat ☐2% fat ☐Whole milk) ☐Soy milk ☐Rice milk

Average ounces per day (Note: 8 ounces = 1 cup) _____________

SLEEP

Hours per night _______________ Naps (number & length) _________________________________

Any sleep problems? ____

DEVELOPMENT

At what age did your child: Sit alone ________ Walk alone ________ Say words ________ Toilet train (daytime) __________

Girls only: Age at first menstrual period_____

DENTAL HISTORY: Has child been seen by a dentist? ☐ No ☐ Yes If so, how often?________ Date of last visit ________________

***IMMUNIZATION/INFECTIOUS DISEASES**: Please bring your child's immunization records to your appointment.

Has your child had: ☐Chickenpox ☐Measles ☐Mumps ☐Rubella ☐Meningitis ☐Tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) ☐No ☐Yes

Do any household members smoke? ☐No ☐Yes

TV-hours per day _________ Computer-hours per day _________ Video games-hours per day __________

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.

____
____
____

Hospitalizations/operations (with dates):

____
____

Broken bones or severe sprains:

____

(Turn page over and complete the other side)

FAMILY HISTORY:
Please indicate with a check (☑) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
Autoimmune Disorder												
Bleeding Disorder												
Cancer, Breast												
Cancer, Melanoma												
Cancer, Ovary												
Congenital Anomaly/Birth Defect												
Heart Attack/Heart Disease												
Depression												
Diabetes, on insulin shots												
Diabetes, not on insulin												
Eczema												
Food Allergy												
Genetic Disorder												
Hay Fever												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Mental Retardation or Learning Disability												
Stroke												
Substance Abuse												
Thyroid Disorders												
Tobacco Use												
Tuberculosis												
Death before age 56 for reason not listed												
Other:												
Other:												

SOCIAL HISTORY

Who lives at home?

Name Age Relationship Highest Education Level

____
____
____
____
____

Are your child's parents ☐Married ☐Unmarried ☐Separated ☐ Divorced If divorced or separated, when? ____________

Mother's Occupation ____________________ Mother's Employer ____________________

Father's Occupation ____________________ Father's Employer ____________________

Childcare situation ☐Parents ☐Others (specify who and hours per day) ____________________

Concerns about your child: ☐Alcohol use ☐Tobacco ☐Sexual activity ☐Aggressive behavior

Is violence at home a concern? ☐No ☐Yes Are there guns in the home? ☐No ☐Yes

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐No ☐Yes

Current Grade _______ Name of School ______________________________

Any concerns about school performance? ______________________________

Any concerns about relationships with Teachers ☐No ☐Yes Students ☐No ☐Yes

If more than 4 years old: does your child have a best friend? ☐No ☐Yes

Sports/exercise: Type ________________ How often? ________________ How long (minutes) ______________