Pediatric Health History

Sound Health Care CENTER

PATIENT INFORMATION

DATE _____

Full Name _____

Social Security # _____ Date of Birth (mm/dd/yyyy) _____

Gender: ☐ Male ☐ Female

REASON FOR TODAY'S VISIT

_____

CURRENT MEDICATIONS/ VITAMINS/SUPPLEMENTS — DOSE

MEDICATION ALLERGIES — REACTIONS

PAST MEDICAL HISTORY

Vaccines up to date? ☐ No ☐ Yes Last tetanus: _____

Pregnancy/Neonatal Period:

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

Pregnancy complications: _____

Delivery by: ☐ Vaginal ☐ C-Section

Reason for C-Section: _____

Complications: _____

Was your child premature? ☐ No ☐ Yes, born at_____weeks

Complications: _____

Any problems as a newborn: _____

MEDICAL CONDITIONS AND DATE DIAGNOSED

_____

HOSPITALIZATIONS

_____

PHYSICIANS INVOLVED IN CARE: (NAME/SPECIALTY)

_____

SURGERIES — DATE

DEVELOPMENT & NUTIRTION

Any problems or concerns about school performance? _____

Any other problems or concerns? _____

FAMILY HISTORY

Relation	Age	Age at Death	Significant Health Issues
Father			
Mother			
☐Brother ☐ Sister			
☐Brother ☐ Sister			
☐Brother ☐ Sister			
☐Brother ☐ Sister			

SOCIAL HISTORY

Who lives in the household with child?

☐ Dad ☐ Mom ☐ Siblings (# ___) ☐ Grandparents ☐ Other: _____

Child's parents are: ☐ Married ☐ Unmarried ☐ Divorced ☐ Other

Do any household members smoke? ☐ No ☐ Yes

How many hours per day does your child spend:

Watching TV: _____ Computer: _____ Video Games: _____

Sports/exercise? _____

How often? _____ Length: _____

THIS SECTION TO BE COMPLETED BY PATIENTS 12 YEARS AND OLDER

HABITS (If yes, Daily Amount)

Cigarettes: ☐ Never ☐ Current Smoker _____

Years Smoked: _____ Quit Date: _____

Caffeine: ☐ Never ☐ Coffee _____

☐ Tea _____ ☐ Soda/Energy Drinks _____

Alcohol: ☐ Non-Drinker ☐ Current Use: _____

Drug Use: ☐ Never ☐ Yes, type: _____

Do you have any concerns about the following?

Safety issues?	☐ No	☐ Yes	
Substance abuse?	☐ No	☐ Yes	
Sexually Transmitted Diseases	☐ No	☐ Yes	
Family Planning	☐ No	☐ Yes	
Other	☐ No	☐ Yes	

Are you sexually active? ☐ No ☐ Yes

If yes, do you use birth control/protection? ☐ No ☐ Yes

Have you ever been pregnant or fathered a child? ☐ No ☐ Yes

Females, have you begun your menstrual cycle? ☐ No ☐ Yes

If yes, when: _____