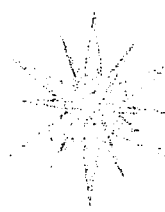


Patient Name _____
Date Of Birth _____
Date _____

(Patient Label)



PrairieStar Health Center

PEDIATRIC HEALTH HISTORY FORM

Your name and relationship to child _____

Present health concerns _____

Medicines/Vitamins _____

ALLERGIES _____

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 _____

Delivery by Vaginal birth Caesarean

If Caesarean, why? _____

Birth weight _____ Birth Length _____

APGAR score 1 minute _____ 5 minute _____

Please indicate any medical problems during the baby's newborn period None Other _____

Nutrition & Feeding

Was your child breastfed? Yes No

If so, how long? _____

Has your child had any unusual feeding/dietary problems?

No Yes (specify) _____

Milk intake now: Type: Cow's milk Nonfat 1% Milk

2% Milk Whole Milk Soy Milk Rice Milk

Averages ounces per day (Note: 8 ounces = 1 cup) _____

Sleep

Hours per night _____

Naps (number and length) _____

Any sleep problems? _____

Development

At what age did your child: Sit alone _____ Walk _____

Toilet train _____ Girls only: Age first menstrual period _____

Dental History

Has child been seen by a dentist? Yes No

If so, how often? _____ Date of last visit _____

Immunizations/Infectious Diseases

Please bring your child's immunization records to your appointments, give a current copy to your provider.

Has your child had any of the following diseases?

Chickenpox Measles Mumps

Rubella Meningitis Tuberculosis (TB)

Exposure/Habits

Any concerns about lead exposure?

Old house(1960 & older)/plumbing/peeling paint No Yes

Do any household members smoke? No Yes.

TV: Hours per day _____ Computer/Video: _____

Past Medical History

Please describe any major problems and their dates _____

Hospitalizations/operations (with dates) _____

Broken bones or severe sprains _____

Family History

Please indicate family members with any of the following conditions (Parent, sibling, grandparent, aunt, uncle)

Alcoholism _____

High Cholesterol _____

Cancer (specify type) _____

High Blood Pressure _____

Heart Disease _____

Stroke _____

Depression/Suicide _____

Bleeding or clotting Disorder _____

Genetic Disorders _____

Asthma/COPD _____

Diabetes _____

Seizure Disorder _____

Other _____

Social History

Who lives at home?

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Mother's occupation _____

Father's occupation _____

Child care situation Parents Day care Other _____

Any concerns about your child:

Alcohol use Tobacco Sexual Activity 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? Yes No

Current Grade _____ Name Of School _____

Any concerns about school performance? _____

Any concerns about relationships with:

Teachers No Yes

Peers No Yes

If more than 4 years old, does your child have a best friend?

Yes No

Sports/exercise:

Type _____

How often? _____

Review Of Symptoms

Please check any current problems your child has on the list below:

General

_____ Fevers/chills/excessive sweating

_____ Unexplained weight loss/gain

Eyes

_____ Squinting/crossed eyes/asymmetric gaze

Ears/Nose/Throat

_____ Unusually loud voice/hard of hearing

_____ Mouth breathing/snoring

_____ Bad breath

_____ Frequent runny nose

_____ Problems with teeth/gums

Cardiovascular

_____ Tires easily

_____ Shortness of breath

_____ Fainting

Respiratory

_____ Cough/wheeze

_____ Chest pain

Gastrointestinal

_____ Nausea/vomiting/diarrhea

_____ Constipation

_____ Blood in bowel movement

Genitourinary

_____ Bedwetting

_____ Pain in urination

_____ Discharge: penis or vagina

Musculoskeletal

_____ Muscle/joint pain

Skin

_____ Rashes

_____ Unusual moles

Allergy

_____ Hay fever/itchy eyes

Neurological

_____ Headaches

_____ Weakness

_____ Clumsiness

Psychiatric/Emotional

_____ Speech problems

_____ Anxiety/stress

_____ Sleep issues

_____ Depression

_____ Nail biting/thumb sucking

_____ Bad temper/breath holding/jealousy

Blood/Lymph

_____ Unexplained lumps

_____ Easy bruising/bleeding

Comments

PROVIDER SIGNATURE

DATE