PEDIATRIC HEALTH HISTORY SHEET

Welcome to our practice. To provide you with the best, most comprehensive care possible for your child, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name: First: Age: Sex:

Doctor Notes
Please do not write in this area

Reason for today's visit:

Past Illness: please indicate any known medical problems:

	Y	N		Y	N
Congenital heart disease	☐	☐	Epilepsy/seizures	☐	☐
Heart murmur	☐	☐	Attention deficit disorder	☐	☐
Asthma	☐	☐	Gallstones	☐	☐
Diabetes	☐	☐	Fractures	☐	☐
Thyroid disease	☐	☐	Gastroesophageal reflux	☐	☐
Failure to thrive	☐	☐	Developmental delay	☐	☐

Please indicate other known medical problems:

Surgical History: Please list any operations:

Have there been any bleeding problems? Y / N
Have there been problems with anesthesia? Y / N
Has there ever been a blood transfusion? Y / N

MEDICATIONS (name/dose)	**ALLERGIES**(drug/reaction) NONE
	LATEX ALLERGY? Y / N

FAMILY HISTORY: (please indicate conditions such as heart disease, stroke, diabetes, cancer, blood disorders)

SOCIAL HISTORY: patient lives with
Mother / Father / Both # of siblings?_____
In foster care – how long? In care center – how long?

RISK FACTORS: Any environmental exposure to smoke? Y / N

****PLEASE COMPLETE AND SIGN REVERSE SIDE****

Please review the following questions and mark the appropriate answer. These are simply screening questions to alert us to any other conditions your child may have.

REVIEW OF SYSTEMS						**Doctor's Notes**
Constitutional	Y	N	**Head and Neck**	Y	N	
Weight gain/loss	☐	☐	Headaches/migraines	☐	☐	
Fevers/night sweats	☐	☐	Enlarged lymph glands	☐	☐	
Fatigue/loss of energy	☐	☐	Other neck masses	☐	☐	
Cardiac	Y	N	**Pulmonary**	Y	N	
Irregular heart beat	☐	☐	Wheezing	☐	☐	
Chest pain	☐	☐	Coughing	☐	☐	
lightheadedness	☐	☐	Shortness of breath	☐	☐	
Gastrointestinal	Y	N	**Genitourinary**	Y	N	
Abdominal pain	☐	☐	Pain with urinating	☐	☐	
Nausea/vomiting	☐	☐	Blood in urine	☐	☐	
Constipation or diarrhea	☐	☐	Groin pain	☐	☐	
Endocrine	Y	N	**Hematologic**	Y	N	
Heat/cold intolerance	☐	☐	Abnormal bleeding/bruising	☐	☐	
Excessive thirst/appetite	☐	☐	Loss of energy	☐	☐	
Excessive hair growth	☐	☐	Exposure to mono/ticks	☐	☐	
Musculoskeletal	Y	N	**Neuropsychiatric**	Y	N	
Joint pain/swelling	☐	☐	Attention deficit	☐	☐	
Muscle pain/weakness	☐	☐	Mood swings/depression	☐	☐	
scoliosis	☐	☐	seizures	☐	☐	

Thank you for providing us with this important information.

Signature/Date: _____