Choice Pediatrics Health History form

Child's Name_____ Date of Birth: _____

Child's Medical Questionnaire

Pregnancy History	YES	NO
Premature Delivery		
Cesarean (C) or Vaginal Birth (V)	C	V
Smoked Cigarettes		
Drank Alcohol		
Used (illegal) drugs		
Difficult delivery		
Had to take medications		

Any other Pregnancy Problems:_____

_____

Birth Hospital:

Length of Pregnancy: _____weeks

Birth Weight: _____lbs _____oz

Newborn/Infant Problems	Yes	No	Newborn/Infant Problems	Yes	No
Trouble Breathing			Given Any Medications		
Needed oxygen/Turned Blue			Had Seizure (fits/convulsions)		
Jaundiced(turned yellow)			Was jittery		
Was a Multiple			Feeding Problems/Vomiting		
Birth defect			Had an Infection		
Hospitalized More than seven days			Was in the neonatal intensive care unit		
Any other Newborn/Infant Problems:					

Health Problems	Yes	No	Health Problems	Yes	No
Allergies/Sensitivities			Kidney/Urinary Problems		
Rashes/Skin Problems			Bowel Problems or constipation		
Asthma or reactive airway disease			Slow Weight Gain		
Wheezing/bronchiolitis/breathing treatments			Anemia		
Ear Infections			Poisoning/Overdose		
Trouble Hearing			Serious Injury		
Trouble with Eyes or Vision			Hospitalized		
Seizures/Convulsions/Spells			Surgeries/operations		
Meningitis			Heart Problems		
Sinusitis			Pneumonia		
Are Immunizations Up to Date?			Urinary Tract Infections		
Learning disability or developmental delay			Depression/anxiety		
Any other Illnesses or Disorders?					

Please Explain Any "Yes" answers:

Current Medications:	

Allergies (drug, food, & others):	

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Social History Questionnaire

Who lives in the household with the child? [ ] Mom [ ] Dad [ ] Sibling (#_____) [ ] Grandparents [ ] Other_____

Child's parents are [ ] Married [ ] Unmarried [ ] Divorced

Does the child attend out of home daycare? [ ] Yes [ ] No

Does anyone in the household smoke? [ ] Yes [ ] No

Are there any pets in the home? [ ] Yes [ ] No If yes, what kind?:_____

Child's home has: [ ] Well water [ ] City water

School name_____ Grade_____

Concerns about school performance [ ] No [ ] Yes, (explain)_____

Family History Questionnaire

Please check YES or NO if anyone in the child's immediate family has or had the following conditions. In the 3rd column please note which family member has or had the condition. **MGM**=Maternal Grandmother **MGF**=Maternal Grandfather **PGM**=Paternal Grandmother **PGF**=Paternal Grandfather **A**=Aunt **U**=Uncle **M**=Mother **F**=Father **S**=Sibling

Condition	Yes	No	Family Member	Condition	Yes	No	Family Member
Birth Defect				Hearing Problems Before age 50			
Sudden Infant Death				Recurrent Ear Infections			
Cancer				Muscle Disease			
Thyroid Problems				Back/Hip Problems Before age 50			
Diabetes				Arthritis/Joint Problems Before age 50			
Allergy/Hay Fever				Brain or Nerve Disease/Seizures			
Eczema/Recurrent Rash				Slow Development			
Asthma				Learning Disability			
Cystic Fibrosis				Emotional/Behavioral Problems			
Heart Disease/Stroke before age 50				Hyperactivity/Inattention			
High Cholesterol				Alcohol/Drug/Substance Abuse			
High Blood Pressure				AIDS/Tuberculosis/Hepatitis			
Bleeding Disorder				Sexual Abuse			
Anemia				Physical Abuse			
Kidney/Bladder Problems				Stomach Problems			
Eye Problems				Any other illnesses			