Doctors for Kids, PLC
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Pediatrics History Form

Dear Parent:
This is a health questionnaire on your child. **Please complete this form. Bring it with you at the time of an appointment.**

Date completed:_____
Child's Name:_____ Date of Birth:_____
Contact Information for Parent 1
Name:_____ Email:_____
Home Address:_____
Home Phone:_____ Work Phone:_____ Cell/Other:_____
Contact Information for Parent 2
Name:_____ Email:_____
Home Address:_____
Home Phone:_____ Work Phone:_____ Cell/Other:_____
This child lives with: □ Mother □ Father □ Mother/Father □Mother/Partner □ Father/Partner □ Grandparent/Other

FAMILY HISTORY

1. Parent 1 Age:_____ Current Health:_____
   Past Health Problems:_____
   Ethnicity:_____ Education/Training:_____
2. Parent 2 Age:_____ Current Health:_____
   Past Health Problems:_____
   Ethnicity:_____ Education/Training:_____
3. Marital Status of Parents:_____
4. Other Children in Family:

Date of Birth	Gender	Name	Healthy or Medical Issues?

5. Are there cultural or religious practices that might affect your child's medical care? □ no □ yes
   If yes, please explain (e.g. blood transfusion, dietary rules, etc.):_____
6. Is there tobacco use in/around your household? □ no □ yes
7. Is there a history in the **family/a blood relative** of:

				If yes, state relationship to child
a.	Allergies	□ no	□ yes	
b.	Anxiety	□ no	□ yes	
c.	Asthma	□ no	□ yes	
d.	Birth Defects/Genetic Problems	□ no	□ yes	
e.	Cancer			
i.	Brain	□ no	□ yes	
ii.	Breast	□ no	□ yes	
iii.	Colon	□ no	□ yes	
iv.	Ovarian	□ no	□ yes	
v.	Skin	□ no	□ yes	
vi.	Thyroid	□ no	□ yes	
vii.	Other (describe and state relationship to child):			
f.	Depression	□ no	□ yes	

				If yes, state relationship to child
g. Diabetes	☐ no	☐ yes	
h. Hearing Loss	☐ no	☐ yes	
i. Heart Attack	☐ no	☐ yes	
j. Heart Disease	☐ no	☐ yes	
k. Hepatitis	☐ no	☐ yes	
l. High Blood Pressure	☐ no	☐ yes	
m. High Cholesterol	☐ no	☐ yes	
n. Learning Disability	☐ no	☐ yes	
o. Mental Illness	☐ no	☐ yes	
p. Seizures	☐ no	☐ yes	
q. Thyroid Problems	☐ no	☐ yes	
r. Tuberculosis	☐ no	☐ yes	

PRENATAL HISTORY

1. While pregnant, did mother have:
   a. Bleeding or spotting ☐ no ☐ yes
   b. German measles (Rubella) ☐ no ☐ yes
   c. Gestational diabetes ☐ no ☐ yes
   d. High blood pressure ☐ no ☐ yes
   e. Illness other than cold/flu ☐ no ☐ yes
   f. Kidney disease ☐ no ☐ yes
   g. Premature labor ☐ no ☐ yes
   h. Threatened miscarriage ☐ no ☐ yes
   i. Toxemia ☐ no ☐ yes
2. Were medications or herbs taken during pregnancy? ☐ no ☐ yes
   If yes, what kind:
3. Was a fertility treatment used for this pregnancy? ☐ no ☐ yes
   If yes, what kind:

BIRTH HISTORY

1. Where was child born:
2. Was labor induced? ☐ no ☐ yes
3. Was labor helped by medication? ☐ no ☐ yes
4. Duration of labor:
5. Was child born early (less than 38 weeks)? ☐ no ☐ yes
6. Was child born late (after 42 weeks)? ☐ no ☐ yes
7. What was the method of delivery:
   ☐ Breech
   ☐ Caesarean (Please state reason):
   ☐ Forceps
   ☐ Spontaneous vaginal
8. Child's birth weight:
9. Apgar Score (if known):
10. During the hospital stay, did child have any of the following:
    a. Antibiotic treatment ☐ no ☐ yes
    b. Blue spells ☐ no ☐ yes
    c. Convulsions ☐ no ☐ yes
    d. Jaundice ☐ no ☐ yes
    e. Skin rash ☐ no ☐ yes
    f. Did child remain in hospital longer than mother? ☐ no ☐ yes
11. How was/is baby fed?
    ☐ Bottle
    ☐ Breast

DEVELOPMENTAL HISTORY:

1. At what age did child: Age
   a. Hold up head
   b. Roll over
   c. Sit unsupported
   d. Stand alone

Age

e. Walk _____
f. Talk _____
g. Toilet train _____
h. Feed him/herself _____
i. Dress him/herself _____

IMMUNIZATIONS

PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES

And TB (Tuberculosis) Testing or BCG Vaccination

PAST MEDICAL HISTORY:

1. Has the child had:
   a. Blood: anemia (iron deficiency, Sickle Cell, Thalessemia)_____ ☐ no ☐ yes
   b. Blood transfusions_____ ☐ no ☐ yes
   c. Chicken pox (Varicella)_____ ☐ no ☐ yes
   d. Contusions_____ ☐ no ☐ yes
   e. Convulsions_____ ☐ no ☐ yes
   f. Fractures_____ ☐ no ☐ yes
   g. German Measles (Rubella)_____ ☐ no ☐ yes
   h. Hospitalizations_____ ☐ no ☐ yes
   i. Measles (Rubeola)_____ ☐ no ☐ yes
   j. Meningitis_____ ☐ no ☐ yes
   k. Mumps_____ ☐ no ☐ yes
   l. Operations_____ ☐ no ☐ yes
      If yes, what illness?_____
   m. Poison ingestion_____ ☐ no ☐ yes
   n. Other serious medical illnesses_____ ☐ no ☐ yes
      If yes, what kind?_____
   o. Is your child currently taking any medications, vitamins or herbs?_____ ☐ no ☐ yes

Medication	Strength/Dose	How Often?

   p. Reaction to medication or food (allergy)_____ ☐ no ☐ yes
      If yes, please explain:_____
      _____
   q. Any chronic or recurring pain?_____ ☐ no ☐ yes
      If yes, please explain:_____
2. Eyes:
   a. Any visual problems?_____ ☐ no ☐ yes
   b. Do eyes look crossed?_____ ☐ no ☐ yes
   c. Does the child wear eyeglasses?_____ ☐ no ☐ yes
3. Ears:
   a. Any hearing problems?_____ ☐ no ☐ yes
   b. Three or more ear infections?_____ ☐ no ☐ yes
4. Nose:
   a. Does the child have frequent attacks of sneezing or rubbing his/her nose?_____ ☐ no ☐ yes
   b. Has the child had frequent nose bleeds?_____ ☐ no ☐ yes
5. Throat:
   a. Does your child have three or more strep throat infections per year?_____ ☐ no ☐ yes
6. Heart:
   Have you ever been told your child has
   a. A heart murmur?_____ ☐ no ☐ yes
   b. Heart defect?_____ ☐ no ☐ yes
   c. High blood pressure?_____ ☐ no ☐ yes

7. Lungs:
   Has your child ever had
   a. Asthma/wheezing? ☐ no ☐ yes
   b. Bronchitis or pneumonia? ☐ no ☐ yes
   c. Chronic cough? ☐ no ☐ yes
8. Does your child tire easily? ☐ no ☐ yes
9. Abdomen
   Has your child ever had
   a. Blood in bowel movement? ☐ no ☐ yes
   b. Difficulty with appetite or eating? ☐ no ☐ yes
   c. Frequent abdominal pain? ☐ no ☐ yes
   d. Frequent vomiting or diarrhea? ☐ no ☐ yes
   e. Jaundice? ☐ no ☐ yes
   f. Marked weight loss? ☐ no ☐ yes
      If yes, please explain:
10. Kidney:
   a. Does your child ever complain of burning or frequency of urination? ☐ no ☐ yes
   b. Does your child wet the bed? ☐ no ☐ yes
   c. Has there ever been blood in the urine? ☐ no ☐ yes
   d. Has your child ever had a urinary tract infection? ☐ no ☐ yes
11. Skin:
   a. Acne? ☐ no ☐ yes
   b. Any sensitivity or allergy? ☐ no ☐ yes
   c. Eczema or atopic dermatitis? ☐ no ☐ yes
12. Extremities:
   Has your child
   a. Had weakness or paralysis of arms or legs? ☐ no ☐ yes
   b. A persistent limp? ☐ no ☐ yes
   c. Every worn corrective shoes or braces? ☐ no ☐ yes
13. Neurological:
   Has your child ever had
   a. Breath holding? ☐ no ☐ yes
   b. Convulsions or seizures? ☐ no ☐ yes
   c. Dizziness? ☐ no ☐ yes
   d. Fainting? ☐ no ☐ yes
   e. Frequent headaches? ☐ no ☐ yes
   f. Temper tantrums? ☐ no ☐ yes
14. Is your child:
   a. Impulsive? ☐ no ☐ yes
   b. Lacking in self-control? ☐ no ☐ yes
   c. Overactive? ☐ no ☐ yes
   d. Does your child have problems with:
      i. Attending school? ☐ no ☐ yes
      ii. Attention span? ☐ no ☐ yes
      iii. Learning? ☐ no ☐ yes
      iv. Mood? ☐ no ☐ yes
      v. Parents? ☐ no ☐ yes
      vi. Peers? ☐ no ☐ yes
      vii. Siblings? ☐ no ☐ yes
      viii. Sleep? ☐ no ☐ yes
   e. Are there concerns about physical, sexual or emotional abuse? ☐ no ☐ yes
15. Has your child begun puberty? ☐ no ☐ yes
16. Any other concerns you would like to discuss?

Parent Signature Date Provider Name Date Reviewed