FOR OFFICE USE ONLY: PLEASE CHECK ONE

| | |
|---|---|
| PEDIATRIC PRIMARY CARE | |
| PEDIATRIC BEHAVIORAL HEALTH | |

NORTHERN NEVADA HOPES *your partner in health.*

# **PEDIATRIC** | Initial Health History

Today's Date:_____

_____

CHILD FIRST NAME MIDDLE NAME LAST NAME

_____

Nickname AGE DATE OF BIRTH

Form completed by: _____

Previous healthcare provider? _____

Specialists (past or present)? _____

**Living Arrangements:**

Who does the child live with? (ex. Mother, Father, Siblings, Grandparents)

_____

_____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

_____

**FAMILY STRESSORS** – Please check any stresses in your home or environment:

☐ Job difficulty ☐ Separation/divorce ☐ Domestic Violence ☐ Mental Illness

☐ Drug/alcohol abuse ☐ Incarceration ☐ Difficulty getting enough food

☐ Difficulty with safe, adequate housing

Additional Comments:

_____

_____

**BIRTH HISTORY**

Birth weight: _____ lbs _____oz Birthplace:_____

When was the baby born? ☐ At term ☐ Early ☐ Late If early, how many weeks gestation? _____

Did the mother have any illness or problem with her pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

During pregnancy, did the mother:

Smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use drugs? ☐ Yes ☐ No Medications? ☐ Yes ☐ No

If yes to the above, what and when? _____

Date of adoption (if applicable): _____

Delivered? ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Did the baby have any problems right after birth? ☐ Yes ☐ No If yes, please explain:_____

How was the initial feeding given? ☐ Breast ☐ Bottle If breastfed, how long?_____

Did the baby go home with the mother from the hospital? ☐ Yes ☐ No

If no, please explain: _____

Other comments:_____

**GENERAL**

| | | | |
|---|---|---|---|
| Do you consider your child to be in good health? | ☐ Yes | ☐ No | Explain: _____ |
| Does your child have any medical conditions? | ☐ Yes | ☐ No | Explain: _____ |
| Has your child had serious injuries or accidents? | ☐ Yes | ☐ No | Explain: _____ |
| Has your child ever been hospitalized? | ☐ Yes | ☐ No | Explain: _____ |
| Has your child ever had surgery? | ☐ Yes | ☐ No | Explain: _____ |
| Is your child allergic to any medicines or drugs? | ☐ Yes | ☐ No | Explain: _____ |
| Does your child take any medications regularly? | ☐ Yes | ☐ No | Explain: _____ |
| Are your child's vaccines up to date? | ☐ Yes | ☐ No | Explain: _____ |
| Are any family members smokers? | ☐ Yes | ☐ No | Explain: _____ |
| Are there any guns in the home? | ☐ Yes | ☐ No | Explain: _____ |

**PAST HISTORY** – if applicable, does your **child** have or has he/she ever had:

| | | | |
|---|---|---|---|
| Frequent ear infections/hearing loss | ☐ Yes | ☐ No | Explain: _____ |
| Problems with eyes or vision | ☐ Yes | ☐ No | Explain: _____ |
| Asthma, bronchitis, pneumonia | ☐ Yes | ☐ No | Explain: _____ |
| Nasal allergies | ☐ Yes | ☐ No | Explain: _____ |
| Environmental or food allergies | ☐ Yes | ☐ No | Explain: _____ |
| Any heart problem or heart murmur | ☐ Yes | ☐ No | Explain: _____ |
| Anemia | ☐ Yes | ☐ No | Explain: _____ |
| Frequent abdominal pain/constipation | ☐ Yes | ☐ No | Explain: _____ |
| Bladder or kidney infection/malformation | ☐ Yes | ☐ No | Explain: _____ |
| Bed wetting (after 5 years old) | ☐ Yes | ☐ No | Explain: _____ |
| (F) Has she started her menstrual period? | ☐ Yes | ☐ No | Explain: _____ |
| (F) Problems with periods | ☐ Yes | ☐ No | Explain: _____ |
| Chronic or recurrent skin problem | ☐ Yes | ☐ No | Explain: _____ |
| Frequent headaches | ☐ Yes | ☐ No | Explain: _____ |
| Congenital cataracts or retinoblastoma | ☐ Yes | ☐ No | Explain: _____ |
| Convulsions or neurological problems | ☐ Yes | ☐ No | Explain: _____ |
| Diabetes | ☐ Yes | ☐ No | Explain: _____ |
| Thyroid or other endocrine problems | ☐ Yes | ☐ No | Explain: _____ |

| | | | |
|---|---|---|---|
| Alcohol/Drug use | ☐ Yes | ☐ No | Explain: _____ |
| Head injuries/concussion/loss of consciousness | ☐ Yes | ☐ No | Explain: _____ |
| Bleeding or clotting problems | ☐ Yes | ☐ No | Explain: _____ |
| Blood transfusion | ☐ Yes | ☐ No | Explain: _____ |
| Chickenpox | ☐ Yes | ☐ No | Explain: _____ |
| Organ transplant | ☐ Yes | ☐ No | Explain: _____ |
| Cancer or bone marrow treatment | ☐ Yes | ☐ No | Explain: _____ |
| Chemotherapy | ☐ Yes | ☐ No | Explain: _____ |
| Gender transition | ☐ Yes | ☐ No | Explain: _____ |
| Sexual transmitted infection | ☐ Yes | ☐ No | Explain: _____ |
| Sleep problems | ☐ Yes | ☐ No | Explain: _____ |
| Persistent snoring | ☐ Yes | ☐ No | Explain: _____ |
| Obesity | ☐ Yes | ☐ No | Explain: _____ |
| Dental decay | ☐ Yes | ☐ No | Explain: _____ |
| ADHD/anxiety/mood problems/depression | ☐ Yes | ☐ No | Explain: _____ |

Developmental delay (physical, social, language, learning)

☐ Yes ☐ No Explain: _____

Any other significant problems?

☐ Yes ☐ No Explain: _____

**FAMILY HISTORY** – have any family members had the following:

| | | | | |
|---|---|---|---|---|
| Childhood Hearing Loss | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Nasal Allergies | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Food Allergies | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Asthma | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Tuberculosis | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Heart Disease (before 50) | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Sudden Cardiac Death | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| High blood pressure | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| High cholesterol | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Anemia | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Kidney disease | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Liver disease | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Diabetes (before 50) | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Epilepsy/convulsions | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Alcohol/Drug abuse | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Tobacco Use | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Mental illness/depression | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Developmental delay | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| ADHD | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Immune problems | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| HIV/AIDS | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Cancer (before 55) | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Gastrointestinal problems | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Bleeding Disorder | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Clotting Disorder | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |
| Obesity | ☐ Yes | ☐ No | Who: _____ | Comments: _____ |

Additional Comments:

_____
_____
_____
_____
_____