NORTHERN NEVADA HOPES *your partner in health.*

PEDIATRIC HEALTH HISTORY | New Patient Today's Date:_____

_____

CHILD FIRST NAME MIDDLE NAME LAST NAME

_____

Nickname AGE DATE OF BIRTH

Form completed by: _____

Reason for visit?_____

Previous healthcare provider? _____ Last visit?_____

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 both biological parents, what is the child's custody status? _____

_____

Occupations of adults living with child?

_____

_____

MEDICATIONS

Does your child take any medications regularly? ☐ Yes ☐ No Explain:

_____

_____

Any vitamins, herbs or supplements? ☐ Yes ☐ No Explain:

_____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain:

_____

_____

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PERSONAL MEDICAL HISTORY:

BIRTH HISTORY When was the baby born? ☐ At term (37+ weeks) ☐ Early ☐ Late

If early, weeks gestation? _____

Birth weight: _____ lbs _____oz **or:** _____kg _____g

Birthplace:_____

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

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

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

Date of adoption (if applicable): _____

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: _____

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

CONDITION	NOW	PAST	COMMENTS
ADHD/anxiety/mood problems/depression			
Alcohol/Drug use			
Anemia			
Asthma, bronchitis, pneumonia			
Bed wetting (after 5 years old)			
Bladder or kidney infection/malformation			
Bleeding or clotting problems			
Blood transfusion			
Cancer or bone marrow treatment			
Chemotherapy			
Chickenpox			
Chronic or recurrent skin problem			
Congenital cataracts or retinoblastoma			
Convulsions or neurological problems			
Dental decay			
Developmental delay			
Diabetes			

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CONDITION	NOW	PAST	COMMENTS
Environmental or food allergies			
Frequent abdominal pain/constipation			
Frequent ear infections or hearing loss			
Frequent headaches			
Gender transition			
Head injuries/concussion/ Loss of consciousness			
Heart problem or heart murmur			
Nasal allergies			
Obesity			
Organ transplant			
Persistent snoring			
Problems with eyes or vision			
Sexually transmitted infection problem			
Sleep problems			
Thyroid or other endocrine problems			
(F) Has she started her period?	YES	NO	
(F) Problems with periods	YES	NO	
Any other significant problems?	YES	NO	

GENERAL

Has your child had serious injuries or accidents? ☐ Yes ☐ No

Explain: _____

Has your child ever had **surgery**? ☐ Yes ☐ No

Explain: _____

Has your child ever been **hospitalized**? ☐ 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

If yes, locked away from kids?: _____

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FAMILY HISTORY: Adopted? ☐ Yes ☐ No

Please list any known medical conditions for the relatives listed below.

For example: diabetes, cancer, heart attack, stroke, high blood pressure, high cholesterol, alcohol abuse, drug abuse, depression.

Relative	Alive, age	Deceased, age of death	Medical Condition(s)	Cause of death (if applicable)
Mom				
Dad				
Mom's Dad				
Mom's Mom				
Dad's Dad				
Dad's Mom				
Siblings				
Other Relatives				

Additional Comments:

_____

_____

Is there anything else you would like to share with us about your child?

_____

_____

CASE MANAGEMENT

Do you have access to enough food? ☐ Yes ☐ No

Do you currently have housing? ☐ Yes ☐ No

Do you have transportation to your medical appointments? ☐ Yes ☐ No

Do you have current legal stressors? ☐ Yes ☐ No

Would you like to speak to a case manager today? ☐ Yes ☐ No