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 today?_____

Previous healthcare provider?_____ Last visit?_____

Specialists (past or present)?_____

Living Arrangements:

Who does the child live with (i.e., mother, father, siblings, grandparents)?

_____

_____

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

_____

Occupations of adults living with child?

_____

MEDICATIONS

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

_____

_____

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

_____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No List and 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 chronic or acute infection, 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 Take 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 or she ever had:

CONDITION	NOW	PAST	COMMENTS
ADHD/anxiety/mood problems/depression			
Alcohol/drug use			
Anemia			
Bladder or kidney infection/malformation			
Bleeding or clotting problems			
Blood transfusion, IVIG transfusion			
Cancer or bone marrow treatment			
Chemotherapy			
Chickenpox or measles or tuberculosis			
Cholesterol problems			
Congenital cataracts or retinoblastoma			
Dental problems or cavities			
Developmental delay			
Diabetes			
Ear problems (frequent ear infections, hearing loss, wax impaction, etc.)			
Environmental or food allergies			
Eye or vision problems			

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CONDITION	NOW	PAST	COMMENTS
Frequent ear infections or hearing loss			
Frequent headaches			
GI issues (chronic abdominal pain, constipation, lactose intolerance, celiac,			
Gender transition or questioning			
Head injuries/concussion/loss of consciousness			
Heart problem or heart murmur			
Hormone problems (thyroid, growth hormone, PCOS, etc.)			
Lung problems (asthma, pneumonia)			
Obesity			
Organ transplant			
Seizures or neurological diseases			
Sexually transmitted infections			
Skin conditions (eczema, acne, etc.)			
Sleep problems (bedwetting after 5yo, snoring, sleep apnea, etc.)			
(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, are they locked away from kids?: _____

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FAMILY HISTORY:
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				

Patient Adopted? ☐ Yes ☐ No
Additional comments about family health:

_____

_____

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

_____

_____

_____

_____