PEDIATRIC HEALTH RECORD

Dear Parents: Welcome to our office. While the following form may take a few minutes to complete, please fill in as much as possible. The information that you provide will help us to take better care of your child today and in the future.

Name: _____ Sex: M or F
Date of Birth: _____ Race: _____
Age: _____ Parent/Guardian Name: _____

What is the chief reason that your child is being seen today? _____
_____
_____

Are there other problems that you are concerned about? _____
_____
_____

Has your child ever	Please list circumstances
Been hospitalized?	
Had an operation?	
Been in a serious accident?	
Had an allergic reaction or problem with any foods?	
Had an allergic reaction to A medicine or shot?	

Please list any medicines that your child takes on a regular basis including over the counter medicines _____
_____

Has your child taken any medicines today? _____
_____

Immunization History:

Are your child's immunizations up to date? YES or NO
If your child is over 1, has he had the chickenpox vaccine? YES or NO
If your child is over 6, has he had the second MMR? YES or NO
Has your child had the Hepatitis B Vaccine series? YES or NO

Please provide our office with a copy of your child's shot record.

Current Grade in school _____ Any concerns regarding school? _____

_____

_____

_____

Are there any smokers in the home? _____
Does your child attend day care? _____
Do you have any concerns regarding your child's behavior?

_____

_____

_____

Medical History: Has your child ever had?

Complications at Birth	Yes	No	A blood transfusion	Yes	No
Whooping cough (pertussis)	Yes	No	Seizures or convulsions	Yes	No
Chicken Pox	Yes	No	Asthma or wheezing	Yes	No
Scarlet fever	Yes	No	Kidney problems	Yes	No
Meningitis	Yes	No	Bladder or urine infection	Yes	No
Repeated ear infections	Yes	No	Heart murmur	Yes	No
Pneumonia	Yes	No	Hearing problems	Yes	No
Anemia	Yes	No	Loss of consciousness	Yes	No
Jaundice	Yes	No	Speech problems	Yes	No
Chronic constipation	Yes	No	Rheumatic fever	Yes	No
Broken bones	Yes	No	Skin problems/chronic rash	Yes	No
Persistent diarrhea	Yes	No	Tuberculosis	Yes	No
Syphilis or gonorrhea	Yes	No	Allergies/hay fever	Yes	No

_____

For infants less than 1 year:

Was this child breast fed? Yes or No For how long?

What type formula did you use?

For girls over age 10:

Have your menstrual periods started? Yes or No At what age?

Are your periods regular: Yes or No

Do you have pain or cramps? Yes or No

Family History: (has any blood relative ever had?)

Heart trouble before age 50	Yes	No	Cancer	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Stroke before age 60	Yes	No	Diabetes	Yes	No
Lung disease before age 40	Yes	No	Anemia	Yes	No
Blindness before age 50	Yes	No	Sickle Cell Disease	Yes	No
Color Blindness	Yes	No	Migraine	Yes	No
Nervous Breakdown	Yes	No	Asthma	Yes	No
Kidney Trouble	Yes	No	Allergies, Hay Fever	Yes	No
Easy Bleeding	Yes	No	Obesity	Yes	No
Congenital Malformations	Yes	No	Retardation	Yes	No
Convulsions or seizures	Yes	No	Deafness	Yes	No
Cystic Fibrosis	Yes	No	Thyroid Trouble	Yes	No

Are there any other health problems that run in your family? _____

_____

_____

	Age	Health Status
Mother		
Father		
Father's Father		
Father's Mother		
Mother's Father		
Mother's Mother		
Sibling		
Sibling		
Sibling		
Sibling		

Are there any significant family or marital problems? _____

_____

_____

_____

I have completed the above form thoroughly and to the best of my knowledge.

Parent's Signature _____