

Pleasant Hill Wellness Center  
Pediatric History Form

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

Child's previous doctor/ primary care provider: \_\_\_\_\_

PRESENT HEALTH CONCERNS: \_\_\_\_\_  
\_\_\_\_\_

PAST MEDICAL HISTORY (please describe all major medical problems and their dates):  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/ Operations (with dates): \_\_\_\_\_  
\_\_\_\_\_

Broken bones/ severe sprains: \_\_\_\_\_

**PREGNANCY & BIRTH**

Is this child yours by:  birth  adoption  stepchild  other: \_\_\_\_\_

Please indicate any medical problems during pregnancy  none  specify: \_\_\_\_\_  
\_\_\_\_\_

Delivery by:  vaginal birth  cesarean If cesarean, why? \_\_\_\_\_

Please indicate problems during the newborn period  none  Premature, how early? \_\_\_\_\_

Other problems: \_\_\_\_\_  
\_\_\_\_\_

**NUTRITION & FEEDING**

Was your child breastfed?  No  Yes If so, how long? \_\_\_\_\_

Has your child had any unusual feeding/ dietary problems?  No  Yes, please specify \_\_\_\_\_  
\_\_\_\_\_

Milk intake now:  Cow milk ( whole  2%  1%  skim)  Soy  Other: \_\_\_\_\_

Average ounces per day (Note: 8 oz are in 1 cup) \_\_\_\_\_

Juice and soda intake (oz per day) \_\_\_\_\_

MEDICINES/ VITAMINS \_\_\_\_\_

HERBS/ HOME REMEDIES \_\_\_\_\_

ALLERGIES/ REACTIONS TO MEDS OR VACCINES \_\_\_\_\_

IMMUNIZATIONS/ INFECTIOUS DISEASES: please bring your child's immunization record to the office

Has your child had:  chickenpox  measles  mumps  rubella  meningitis  tuberculosis (TB)

SLEEP Hours/ night \_\_\_\_\_ Naps (No. & length) \_\_\_\_\_

Any sleep problems? \_\_\_\_\_

DEVELOPMENT At what age did your child: sit alone \_\_\_\_\_ Walk alone \_\_\_\_\_

Say words \_\_\_\_\_ Toilet train \_\_\_\_\_ (Girls only): begin menses' \_\_\_\_\_

DENTAL HISTORY Has child been seen by a dentist?  No  Yes how often? \_\_\_\_\_ date of last visit \_\_\_\_\_

EXPOSURES/ HABITS Concerns about lead exposure? (old home, plumbing, peeling paint)  No  Yes

Household smokers?  No  Yes TV(hrs per day) \_\_\_\_\_ Computer/video games (hrs per day) \_\_\_\_\_

Sports/ exercise: \_\_\_\_\_ Hours per week \_\_\_\_\_

**FAMILY HISTORY:** Please circle any family history of the following & indicate who has/ had the condition

Asthma/hayfever/eczema _____	Inherited/ genetic disease _____	Alcohol/drug abuse _____
Heart disease/stroke before age 60 _____	Bleeding/clotting problem _____	Seizures _____
High blood pressure _____	Birth defects _____	Kidney disease _____
High cholesterol _____	Psychiatric disorders _____	Thyroid disease _____

**SOCIAL HISTORY:** Birthplace \_\_\_\_\_ Who lives at home? (write below)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Highest Education Level</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the child's parents  married  unmarried  separated  divorced If divorced, when? \_\_\_\_\_  
 Parents' occupations: Mother \_\_\_\_\_ Father \_\_\_\_\_  
 Child care situation  parents  Others (specify who, hours per day) \_\_\_\_\_

Concerns about your child:  Alcohol use  Tobacco  Drugs  Sexual activity  Aggressive behavior  
 Is violence at home a concern?  No  Yes Are there guns in the home?  No  Yes

**SCHOOL HISTORY**

Did/ does your child attend preschool?  Yes  No Current Grade \_\_\_\_\_ Name of School \_\_\_\_\_  
 Any concerns about school performance? \_\_\_\_\_  
 Any concerns about relationships with Teachers?  Yes  No Students?  Yes  No  
 If over 4 years old, does your child have a best friend?  Yes  No

**REVIEW OF ORGAN SYSTEMS:** If child has more than one symptom on a line, please circle the relevant ones

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| <p><u>Constitutional/ Endocrine</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> fevers/chills/excessive sweating</li> <li><input type="checkbox"/> unexplained weight loss/ gain</li> </ul> <p><u>Eyes</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> squinting/ "crossed eyes/ asymmetric gaze</li> </ul> <p><u>Ears/ Nose/ Throat</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> unusually loud voice/ hard of hearing</li> <li><input type="checkbox"/> mouth breathing/ snoring</li> <li><input type="checkbox"/> bad breath</li> <li><input type="checkbox"/> frequent runny nose</li> <li><input type="checkbox"/> problem with teeth/ gums</li> </ul> <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> cough/ wheeze</li> </ul> <p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> muscle/ joint pain</li> </ul> | <p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> nausea/vomiting/diarrhea</li> <li><input type="checkbox"/> constipation</li> <li><input type="checkbox"/> blood in bowel movement</li> </ul> <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> tires easily with exertion</li> <li><input type="checkbox"/> shortness of breath</li> <li><input type="checkbox"/> fainting</li> </ul> <p><u>Genitourinary</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> bedwetting</li> <li><input type="checkbox"/> pain with urination</li> <li><input type="checkbox"/> discharge penis/ vagina</li> </ul> <p><u>Neurological</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> headaches</li> <li><input type="checkbox"/> weakness/ clumsiness</li> </ul> | <p><u>Allergy</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> hayfever/ itchy eyes</li> </ul> <p><u>Skin</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> rashes</li> <li><input type="checkbox"/> unusual moles</li> </ul> <p><u>Psychiatric/emotional</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> speech problems</li> <li><input type="checkbox"/> anxiety/ stress</li> <li><input type="checkbox"/> sleep issues/ nightmares</li> <li><input type="checkbox"/> depression</li> <li><input type="checkbox"/> nail biting/thumbsucking</li> <li><input type="checkbox"/> bad temper/ breath holding/ jealousy</li> </ul> <p><u>Blood/ lymph</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> unexplained lumps</li> <li><input type="checkbox"/> easy bruising/ bleeding</li> </ul> |
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