

Health History Form - Pediatrics

Patients height?

Patients weight?

Hand Preference

R L B

Staff to complete

BP

BMI

OFC

Patient Name:

Birth Date:

Gender:

Appt Date:

MRN:

Rendering Provider:

Injury / Illness Information

Chief Complaint:

How long have you had this problem? How did symptoms start? suddenly gradually chronic

Have you experienced similar problems in the past? No Yes If injury related, date of injury: / /

REFERRING PHYSICIAN

PRIMARY PHYSICIAN

Referring Physician

Primary Physician

Please check and include last date of treatment for any of the following (mm/yyyy) None

	mm/yyyy	Back	Neck	Brain	Abdomen
<input type="checkbox"/> MRI	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> CT	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> X-Rays	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ultrasound	<input type="text"/>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Angiogram	<input type="text"/>			<input type="checkbox"/>	

	mm/yyyy	Upper Extremity	Lower Extremity
<input type="checkbox"/> EMG	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Name of facility?
<input type="checkbox"/> Physical Therapy	<input type="text"/>
<input type="checkbox"/> Chiropractic	<input type="text"/>
<input type="checkbox"/> Speech Therapy	<input type="text"/>
<input type="checkbox"/> Urodynamics	<input type="text"/>
<input type="checkbox"/> Nutrition Services	<input type="text"/>
<input type="checkbox"/> Occupational Therapy	<input type="text"/>

PAST SURGICAL HISTORY (list any **surgery** the child has had with the approximate year (yyyy) None

<input type="checkbox"/> Appendectomy	<input type="text"/>	<input type="checkbox"/> Eye Surgery	<input type="text"/>	<input type="checkbox"/> Tonsillectomy	<input type="text"/>
<input type="checkbox"/> Baclofen Pump	<input type="text"/>	<input type="checkbox"/> Gastrostomy Tube	<input type="text"/>	<input type="checkbox"/> Orthopedic Surgery (Hip)	<input type="text"/>
<input type="checkbox"/> Bladder Surgery	<input type="text"/>	<input type="checkbox"/> Hernia Repair	<input type="text"/>	<input type="checkbox"/> Orthopedic Surgery (Leg/Foot)	<input type="text"/>
<input type="checkbox"/> Colostomy	<input type="text"/>	<input type="checkbox"/> Lumbar Puncture	<input type="text"/>		
<input type="checkbox"/> Ear Tubes	<input type="text"/>	<input type="checkbox"/> Shunt Tap	<input type="text"/>		

<input type="checkbox"/> Back Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Brain Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Neck Surgery Surgical Procedure: <input type="text"/>
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<input type="checkbox"/> Back Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Brain Surgery Surgical Procedure: <input type="text"/>	<input type="checkbox"/> Other Surgical Procedure: <input type="text"/>
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MEDICAL HISTORY Please put a check next to the disease below if the child currently has, or has been diagnosed with in the past

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurogenic Bladder | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Autism | <input type="checkbox"/> GERD | <input type="checkbox"/> Neurogenic Bowel | <input type="checkbox"/> Subdural Hematoma |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> OCD | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> HIV | <input type="checkbox"/> Prematurity | <input type="checkbox"/> Tethered Cord Syndrome |
| <input type="checkbox"/> Chiari Malformation | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Kidney Disease | Other |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Retinopathy | <input type="text"/> |

Type of cancer:

Other

Other

MEDICATIONS **NONE**
(List all medications the child is currently taking including herbal and over-the-counter medications)

ALLERGIES **NONE**

Medications child is allergic to:

Other allergies (food, seasonal, etc.)

- Is the child allergic to?
- Adhesive Tape
 - Latex
 - CT Contrast/Kidney Dye/Iodine?
 - Gadolinium/MRI Contrast?

EDUCATION:

Grade in School:

Does your child have a learning disability?

- IEP in place
- math
- reading
- speech
- Title I

Does your child like school? No Yes

Performing: Below grade level
 At grade level
 Above grade level

SOCIAL HISTORY

Lives primarily with:

- Mother
- Father
- Grandmother
- Grandfather
- Foster Mother
- Foster Father
- Aunt
- Uncle

Number of siblings?

TOBACCO USE

Is your child exposed to second hand smoke? Yes No

VACCINATION

Has your child received an influenza vaccination this year?
 No Yes Date

FAMILY HISTORY Please indicate if patient's mother, father or sibling has or had any of the following diseases or it was their cause of death (COD)

Patient is adopted

	Mother		Father		Sister(s)		Brother(s)	
	<i>Now</i>	<i>COD</i>	<i>Now</i>	<i>COD</i>	<i>Now</i>	<i>COD</i>	<i>Now</i>	<i>COD</i>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm/Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family history

REVIEW OF SYSTEMS (Please check if the child had any of the following in the last 6 months)

NONE

- | | | |
|---|---|---|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Visual loss | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Double vision | <input type="checkbox"/> Urinary Frequency |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Urinary Retention |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Coughing | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Nausea | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Insomnia |

Other:

Thank you for completing our patient information form