Cresencia D. Banzuela MD INC

Date_____

PEDIATRIC HEALTH HISTORY FORM

PATIENT'S NAME_____ **DATE OF BIRHT**_____**AGE**_____
MOTHER'S NAME_____**DATE OF BIRTH**_____**OCCUPATION**_____
FATHER'S NAME_____**DATE OF BIRTH**_____**OCCUPATION**_____
PATIENT'S PREVIOUS DOCTOR_____
PRESENT HEALTH CONCERNS_____
MEDICINE/VITAMINS_____**HERBS/HOME REMEDIES**_____
ALLERGIES/REACTIONS TO MEDICINES OR VACCINES_____

1. PREGNANCY & BIRTH

Is this child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Foster ☐Other _____
Please indicate any medical problems during pregnancy: ☐ None If yes, Specify_____
Delivered by: ☐ Vaginal Birth ☐ Caesarian If caesarian, why? _____
Birth weight_____ _____Birth length _____
Please indicate any medical problems during the baby's newborn period: ☐ None ☐ Yes
If premature how early? _____
Other problems _____
Name of Hospital where your child was born: _____

2. NUTRITION & FEEDING

Was your child breastfed? ☐ No ☐ Yes If so, how long? _____
Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes
If yes,
specify_____
Milk intake what type: ☐Cow milk (☐Non fat1%fat ☐2% Fat ☐ Whole milk) ☐Soymilk ☐Other_____
Average ounces per day (Note 8 ounces are in 1 cup) _____

3. SLEEP

Hours per night_____ Naps (number & length) _____Any sleep problems? _____

4. DEVELOPMENT

At what age did your child sit alone: _____ Walk alone: _____ Say words: _____Toilet train: _____
Girls only: Age of first menstrual period:_____

5. DENTAL HISTORY

Has your child seen a dentist? ☐No ☐Yes If so, how often _____ Date of last visit _____

6. IMMUNIZATION

Please bring your child's immunization record to all appointment
Refusal to vaccinate: ☐No ☐Yes Vaccine preference, explain_____ Date of last TB test: _____

7. EXPOSURE/HABBITS

Any concerns about lead exposure? (Old home/pluming/peeling paint) ☐No ☐Yes
Do any household members smoke? ☐No ☐Yes
T.V. hours per day _____ Computer per day _____ Video Games hours per day _____

8. PAST MEDICAL HISTORY

Please describe any major medical problems and their dates:_____
Hospitalizations/surgery (with dates) _____
Has your child ever been treated for or diagnosed with: (explain)
☐ Broken bones or severe sprains _____ ☐ Seizures _____
☐ Asthma or reactive airway disease _____☐ Anemia _____
☐ Wheezing or bronchiolitis _____☐ Genetic syndrome_____ ___
☐ Seasonal allergies or eczema _____ ☐ Depression/anxiety_____
☐ Food allergies _____ ☐ Pneumonia _____
☐ Recurrent ear infection _____ ☐ Urinary infection _____
☐ Mental retardation or learning disability _____
☐ Other _____
Please list specialist your child is currently seeing: _____

9. FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐

Please explain all positives: _____

_____

10. SOCIAL HISTORY

Who lives in the household with your child? ☐ Mom ☐ Dad ☐ Siblings (#____) ☐ Grandparents ☐ Other _____

Child's parents are: ☐ Married ☐ Unmarried ☐ Divorced ☐ Other _____

Childcare: ☐ Parent ☐ Relatives ☐ Daycare ☐ Babysitter/nanny

Does your child attend School? ☐ No ☐ Yes, Grade: _____

Any concerns about school performance: ☐ No ☐ Yes, explain _____

Any concerns about peer or teacher relationships? ☐ No ☐ Yes, explain _____

Sports/exercise: Type _____How often? _____ How long _____min

11. REVIEW OF ORGAN SYSTEM (Please check all symptoms that apply)

Constitutional/Endocrine
- ☐ Fever/chills/excessive sweating
- ☐ Unexplained weight loss/gain

Eyes
- ☐ Squinting/crossed eyes
- ☐ Asymmetric gaze

Ears/Nose/Throat
- ☐ Unusually loud voice hard of hearing
- ☐ Mouth breathing/snoring
- ☐ Bad breath
- ☐ Frequent runny nose
- ☐ Problems with teeth/ gums

Respiratory
- ☐ Cough/Wheeze
- ☐ Chest pain

Muscular/Skeletal
- ☐ Muscle/joint pain

Gastrointestinal
- ☐ Nausea/Vomiting/diarrhea
- ☐ Constipation
- ☐ Blood in bowel movement

Cardiovascular
- ☐ Tires easily with exertion
- ☐ Shortness of breath
- ☐ Fainting

Genitourinary
- ☐ Bed wetting
- ☐ Pain with urinations
- ☐ Discharge Penis or vagina

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness

Blood/Lymph
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Allergy
- ☐ Hayfever/itchy eyes
- ☐ Hives
- ☐ Rashes
- ☐ Unusual moles

Psychiatric/Emotional
- ☐ Speech problems
- ☐ Anxiety/stress
- ☐ Problems with sleep
- ☐ Nightmares
- ☐ Depression
- ☐ Nail biting
- ☐ Thumbsuking
- ☐ Bad temper
- ☐ Breath holding
- ☐ Jealousy

Patient Name:_____ Date of Birth_____

Signature: _____Relationship:_____ Date: _____