PEDIATRIC HEALTH HISTORY SHEET

Welcome to our practice. To provide you with the best, most comprehensive care possible for your child, please provide us with the following in formation. All information will be held strictly confidential and is released only with your written permission

Last name	First name	Age	Gender
Reason for today's visit			

Past medical problems *(check any that apply)*					
Congenital heart disease		Prematurity		Sleep apnea	
Heart murmur		Seizures		Depression	
Asthma		Attention deficit		Anxiety	
Diabetes		Developmental delay		Other:	
Gallstones		Lyme disease			
Gastro-esophageal reflux		Bleeding disorder			

Surgical History *(please list operation and year if known)*			
Medications (name)	**dose & frequency**	**Allergies**	**type of reaction**
		❑ Latex	

Family History (if yes, specify relation see abbreviations)
Mother(M), Father(F), Brother(B), Sister(S), Aunt(Au), uncle(Un), grandmother(GM), grandfather(GF)

❑ Coronary artery disease	❑ Arrhythmias	❑ High BP
❑ Cystic fibrosis,	❑ Lung cancer	
❑ Gallstones	❑ Colon cancer	❑ IBD (Crohn's Dz, UC)
❑ Diabetes	❑ Thyroid disorder	
❑ Hemophilia	❑ Thalassemia	❑ Lymphoma, □ Leukemia
❑ Skin cancer	❑ Breast cancer	
❑ Kidney stones	❑ Anesthesia related disorder (extreme fever, prolonged effect)	

Social History

Patient lives with: □ parents □ mother □ father □ siblings (#)

□ foster parent how long? □ care center

Does pt smoke? Y / N Is there 2nd hand exposure to smoke Y / N

Immunizations/Childhood illnesses

□ up to date □ no recent exposure to communicable diseases □ other

***** PLEASE COMPLETE REVERSE SIDE *****

Patient Name: ______________________________ **Date of Birth:** ______________

REVIEW OF SYSTEMS						*Reviewer's Notes*
Constitutional/general	**yes**	**no**	**Head and Neck**	**yes**	**no**	
fevers /chills			diplopia (double vision)			
sweats			blurry vision / loss of vision			
weight loss/weight gain			photophobia			
fatigue/ lightheadedness			hearing loss / tinnitus			
Skin /Breast			**Neurologic**			
rashes			headache/migraine			
lumps			numbness/tingling			
new lesions/sores			ataxia/paresis/paralysis			
breast pain / nipple discharge			weakness/syncope/seizure			
Cardiovascular			**Respiratory**			
chest pain/palpitations			cough/hemotysis			
orthopnea/edema			wheezing/dyspnea			
syncope			pleuritic chest pain			
claudication			snoring			
Gastrointestinal			**Genitourinary**			
abdominal pain			frequency/urgency/flank pain			
nausea/vomiting			dysuria (pain with urination)			
hematemesis/heartburn			hematuria (blood in urine)			
constipation/diarrhea			incontinence			
hemorrhoids/rectal bleeding			nocturia (frequent nightime voiding)			
Endocrine			**Hematologic**			
heat/cold intolerance			bleeding problems			
polyuria (frequent urine voiding)			swollen glands			
polydipsia (frequent water intake)			spontaneous bleeding			
change in appetite			easy bruisability			
change in menstrual cycle						
Musculoskeletal			**Psychiatric**			
joint pain			depression			
back pain			anxiety			
muscle aches			hallucinations (visions, hearing things)			
stiffness			suicidal ideation			
swelling						

Parent/Guardian Signature: ______________________________ **Date:** ______________