CONE HEALTH®
The Network for Exceptional Care

Name _____ Date _____

Pediatric Health History Form

CHILD'S NAME _____ **DATE OF BIRTH** _____ **AGE** _____

CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER _____

PRESENT HEALTH CONCERNS _____

_____

MEDICINES/VITAMINS _____

HERBS/HOME REMEDIES _____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS _____

PREGNANCY & BIRTH

Is this child yours by ☐ birth ☐ adoption ☐ stepchild ☐ other _____

Please indicate any medical problems during pregnancy ☐ none ☐ specify _____

_____

Delivery by ☐ vaginal birth ☐ Caesarian If Caesarian, why? _____

Birth weight _____ Birth length _____ APGAR score 1 mm _____ 5min _____

Please indicate any medical problems during the baby's newborn period ☐ none If 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 If yes, specify _____

_____

Milk intake now Type ☐ cow milk (☐ non fat ☐ 1%fat ☐ 2%fat ☐ whole milk) ☐ soy milk ☐ rice milk

Average ounces per day (Note 8 ounces are in 1 cup) _____

SLEEP

Hours per night _____ Naps (number & length) _____

Any sleep problems? _____

DEVELOPMENT

At what age did your child sit alone _____ walk alone _____ say words _____ toilet train (daytime) _____

Girls only: Age at first menstrual period _____

DENTAL HISTORY Has child been seen by a dentist? ☐ No ☐ Yes If so how often _____ Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES Please bring your child's immunization records to your appointment

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

EXPOSURES/HABITS Any concerns about lead exposure? (old home/pluming/peeling paint) ☐ No ☐ Yes

Do any household members smoke? ☐ No ☐ Yes

TV – hours per day _____ Computer – hours per day _____ Video Games – hours per day _____

PAST MEDICAL HISTORY Please describe any major medical problems and their dates

_____

_____

_____

Hospitalizations / Operations (with dates) _____

_____

Broken bones or severe sprains _____

— PLEASE COMPLETE BOTH SIDES OF THIS FORM —

FAMILY HISTORY Please circle any family history of the following (indicate who has/had the condition)

Alcoholism/drug abuse
Psychiatric disorders
High blood pressure
Asthma / hayfever / eczema
Heart disease or stroke before age 60
Thyroid disease
Bleeding/clotting problems
Inherited/genetic diseases
Seizures
Kidney disease
Birth defects

SOCIAL HISTORY

Birthplace _____ Current (or upcoming) grade _____

Who lives at home? _____

Name	Age	Relationship	Highest Education Level

Are the child's parents ☐ married ☐ unmarried ☐ separated ☐ divorced If divorced when? _____

Parents' occupations: Mother _____ Father _____

Child care situation ☐ parents ☐ others (specify who and hours per day) _____

Concerns about your child ☐ Alcohol use ☐ Tobacco ☐ 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? ☐ No ☐ Yes Current grade _____ Name of school _____

Any concerns about school performance? _____

Any concerns about relationships with Teachers ☐ No ☐ Yes _____

Students ☐ No ☐ Yes _____

If over 4 years old does your child have a best friend? ☐ No ☐ Yes

Sports / exercise Type _____How often? _____ How long (minutes) _____

REVIEW OF ORGAN SYSTEMS If child has more than one symptom on a line circle the relevant one(s)

Constitutional / Endocrine
- ☐ Fevers/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
- ☐ Clumsiness

Muscular/Skeletal
- ☐ Muscle/joint pain

Gastrointestinal
- ☐ Nausea / vomiting / diarrhea
- ☐ Constipation
- ☐ Blood In bowel movement

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

Genitourinary
- ☐ Bedwetting
- ☐ Pain with urination
- ☐ Discharge penis or vagina

Neurological
- ☐ Headaches
- ☐ Weakness

Allergy
- ☐ Hayfever / itchy eyes

Skin
- ☐ Rashes
- ☐ Unusual moles

Psychiatric / Emotional
- ☐ Speech Problems
- ☐ Anxiety/stress
- ☐ Problems with sleep / nightmares
- ☐ Depression
- ☐ Nail biting / thumbsucking
- ☐ Bad temper/breath holding/ jealousy

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

— PLEASE COMPLETE BOTH SIDES OF THIS FORM —