



Community Health Center

OF THE NORTH COUNTRY

PEDIATRIC HEALTH HISTORY FORM

Patients Name: _____ DOB: _____

Parents/Guardian Names: _____ Date: _____

CHILD'S BIRTH HISTORY:

Please circle and fill in where needed

During your pregnancy with this child, did you:

Have high blood pressure?	Yes	No
Have Diabetes or Sugar in your urine?	Yes	No
Have a urine or kidney infection?	Yes	No
Have any other infections?	Yes	No
Have a venereal disease such as gonorrhea or syphilis?	Yes	No
Take any medications, drugs or alcohol?	Yes	No
Have any problems with labor or delivery?	Yes	No
Was the pregnancy planned?	Yes	No
How long was the pregnancy?	Yes	No
How much did the baby weigh?	Lbs	Oz
Did the child have any problems after birth? If yes, what:	Yes	No
Did the mother and child come home from the hospital together?	Yes	No
How many days did the Mother and Child stay in the hospital?	M:	C:
In which hospital was your child born:		

CHILD'S SOCIAL HISTORY:

Please circle and fill in where needed

Child lives with: Mother Father Both Parents Other Relatives Foster Parents

Who lives with this child?

Name:	Relationship to the child:	Date of Birth:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Does the child spend time regularly with a babysitter?	Yes	No
If yes, how many times per week?		
Does the child spend time at a daycare center?	Yes	No
If yes, how many times per week?		
How many hours per day?		



CHILD'S FAMILY HISTORY:

Please circle and fill in where needed

	Father	Mother	Father's Family	Mother's Family	Brothers	Sisters
Asthma						
Diabetes						
Heart attack at less than 50 years old						
Seizures						
Sickle Cell Disease						

CHILD'S MEDICAL HISTORY:

Please circle and fill in where needed

Is your child currently taking any medication?

Yes

No

If yes, please list:

Does your child have any drug allergies?

Yes

No

If yes, please list:

Does your child have any food/environmental allergies?

Yes

No

If yes, please list:

Has your child ever stayed overnight in the hospital?

Yes

No

(Please use the back of this page if needed to explain)

Year:	Hospital:	Why:
1.		
2.		
3.		

Has your child ever had:

Eczema (Allergic skin rash)?	Yes	No
Chicken Pox?	Yes	No
Anemia?	Yes	No
Asthma?	Yes	No
Rheumatic Fever?	Yes	No
Seizures, convulsions, fits?	Yes	No

Has your child:

Had problems seeing or with eyes?	Yes	No
Had problems hearing or with ears?	Yes	No
Had frequent ear infections?	Yes	No
Had problems with heart?	Yes	No
Had problems with stomach or bowels?	Yes	No
Had broken or fractured bones?	Yes	No
Had problems urinating?	Yes	No
Ever eaten paint, clay, or plaster?	Yes	No
Do you give your child: vitamins, iron, or fluoride? If yes, what?	Yes	No



Child's Development:

Has the child done things (for example, started sitting, walking, talking) at the same time as his or her brothers, sisters, relatives or friends?

Yes**No**

If no, explain:

Child's School History:

If your child is old enough to go to school, where does he/she go? _____ What grade? _____

Has your child ever failed a grade?	Yes	No
Attended a special class?	Yes	No
Had behavior problems in school?	Yes	No

If yes to any of the above questions, please explain:

Child's Behavior:

Has your child had frequent nightmares?	Yes	No
Had problems being overly shy?	Yes	No
Been overly clinging to parents or friends?	Yes	No
Been upset lately?	Yes	No
Been overly nervous?	Yes	No
Been unreasonably jealous?	Yes	No
Does your child lie a lot?	Yes	No
Does your child fight a lot?	Yes	No
Does your child steal?	Yes	No

How would you describe your child and his/her behavior?

Additional Information: