All Star Pediatrics · 6410 Joliet Road, Countryside, IL
Phone 708-352-4448 · Fax 708-352-1052 · aspeds.com

Child Health History

One form per child. Fill in what you know. We'll go over the rest at your first visit.

Child's full name _____ Goes by _____ Date of birth _____

Your relationship to child _____ Date _____

Health Basics

Medicine allergies (and what happens) ☐ None known

Food or other allergies (and what happens) ☐ None known

Medicines, vitamins, and supplements (name and dose) ☐ None

Specialists who see your child (name, specialty)

Are vaccines up to date? ☐ Yes ☐ No ☐ Not sure

Please send your child's immunization (shot) record. It's one of the most helpful things you can share!

Birth History

Hospital or place of birth _____ Weeks pregnant at birth _____ Birth weight _____ Length of hospital stay _____

Delivery: ☐ Vaginal ☐ C-section **Breech?** ☐ Yes ☐ No

Any time in the NICU or special-care nursery? ☐ No ☐ Yes, for how long: _____

Any problems in pregnancy, at birth, or as a newborn? (Like jaundice, breathing, or feeding)

Growth, learning, and development

Any concerns? (check all that apply)

☐ Speech or language ☐ Behavior or attention ☐ Sleep ☐ Mood, worry, or stress
☐ Walking, coordination, or motor skills ☐ Learning or school ☐ Eating or weight ☐ No concerns right now

School / daycare _____ Grade _____ IEP, 504 plan, or therapies (speech, OT, PT)? _____

Medical History

Has your child ever had any of these? Check all that apply. Then tell us more below.

- ☐ Serious injury or accident
- ☐ Surgery
- ☐ Hospital stay
- ☐ Chickenpox
- ☐ Frequent ear or sinus infections
- ☐ Frequent strep / tonsillitis
- ☐ Other serious infections
- ☐ Seasonal allergies (hay fever)
- ☐ Allergies to animals
- ☐ Indoor or outdoor allergies
- ☐ Asthma, wheezing, or pneumonia
- ☐ Heart problem or murmur
- ☐ Frequent belly pain
- ☐ Constipation needing a doctor visit
- ☐ Reflux
- ☐ Urinary tract infections
- ☐ Bedwetting after age 6
- ☐ Eye problems or glasses
- ☐ Ear or hearing problems
- ☐ Eczema, acne, or other skin problem
- ☐ Anemia or bleeding problem
- ☐ Blood transfusion
- ☐ Frequent headaches
- ☐ Seizures
- ☐ ADHD / ADD
- ☐ Bone or joint problems
- ☐ Diabetes
- ☐ Thyroid or other hormone problem
- ☐ Periods have started
- ☐ Problems with periods
- ☐ Emotional or behavioral concerns
- ☐ Alcohol, vaping, or drug use

Tell us more (dates, details, surgeries, hospital stays)

Home and safety

Who lives in your child's home	Relationship	Age

Does anyone smoke or vape in the home or car? ☐ No ☐ Yes

Pets at home? ☐ No ☐ Yes, which: _____

Any firearms in the home? ☐ No ☐ Yes

If yes, are they stored locked and unloaded, with ammunition locked separately? ☐ Yes ☐ No ☐ Not sure

We ask every family these questions. They help keep kids safe. Your answers stay in your child's private medical record.

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Family health history

Has anyone in your child's family (**blood relatives** only) had any of these? Check all that apply. Already filled this out for a brother or sister? Just write "same as _____" here: _____

Condition	Mother	Father	Brother / sister	Maternal grandparents	Paternal grandparents	Aunts / uncles
Allergies (nasal or other)						
Asthma						
Lung disease						
Heart disease						
High blood pressure						
High cholesterol						
Diabetes						
Thyroid disease						
Cancer (please specify below)						
Anemia						
Bleeding disorder						
Seizures or epilepsy						
Developmental disorder or autism						
ADHD or other neurological condition						
Liver disease						
Stomach or bowel disorder						
Kidney disease						
Bedwetting						
Hearing loss						
Hip dysplasia						
Lazy eye or crossed eyes (amblyopia/strabismus)						
Glaucoma or vision loss						
Autoimmune disease						
Alcohol use disorder						
Drug use disorder						
Mental health condition (please specify below)						
Tuberculosis						
Other (please specify):						

Please specify (cancer type, mental health condition, other):

Anything else you'd like us to know about your child or family?