400 McCaslin, #103 * Louisville, CO 80027 * Phone (303) 666.7337 * Fax (303) 666.7379

PEDIATRIC HEALTH HISTORY FORM

Date: ________________________

Child's Name: _________________________ Date of Birth: ______________________ Age: ____________

Present Health Concerns: ____

____

Medicines/Vitamins: ____

Herbs/Home Remedies: ____

Allergies/Reactions to Medications or Vaccinations: ____

____

Past Medical Mistory: Please describe any major medical problems (Asthma, Seizures, Heart Problems, Diabetes, etc)

____

____

____

Hospitalizations/Operations: ____

____

Broken Bones or Severe Sprain: ____

Dental History: Has child been seen by a dentist? __Yes __No If so, how often? _____________________

Date of last visit __________

Immunizations: Please bring your child's immunization records with you.

Immunizations up to date? __Yes __No

Infectious Diseases:

Has your child had: __Chicken Pox __Measles __Mumps __Rubella __Meningitis

__Tuberculosis __Pertussis/Whooping Cough Other _____________________________________

Child's Name: ________________________ Date of Birth: ______________________________________

Family/Social History

Who lives at home?

Name	Age	Relationship

Do both natural parents live at home? ____

Exposures/Habits:

Does anyone in the home smoke? __Yes __No

Are there any pets in the home? __Yes __No

Any concerns about lead exposure? __Yes __No

Pregnancy and Birth

Where was your child born: ____

Is the child yours by: __Birth __Adoption __Stepchild Other: _____________________________

Please indicate any medical problems during the pregnancy: ________________________________

____

Delivery by: __Vaginal birth __Ceasarean If Ceasarean, why? ______________________________

____

Birth Weight: _________ Birth Length: _________ APGAR score 1 min _______ 5 min ________

If premature, how early? ____

Please indicate any medical problems during the baby's newborn period _______________________

____

Child's Name: ________________________ Date of Birth: _____________________

Family History

Please indicate with an X family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Mom's Sister	Mom's Brother	Dad's Mom	Dad's Dad	Dad's Sister	Dad's Brother
Dermatology												
Eczema												
Hearing Disorder												
Environmental Allergies												
Food Allergies												
Respiratory												
Asthma												
Tuberculosis												
Cardiovascular												
Hypertension												
High Cholesterol												
Heart Disease												
Stroke												
Congenital Heart Defect												
Gastrointestinal												
Gallstones												
Irritable Bowel												
Ulcerative Colitis												
Crohn's												
Pyloric Stenosis												
GERD												
Renal Disorders												
Polycystic Syndrome												
Urology												
VU Reflux												
Gynecology												
Rheumatology												
Rheumatoid Arthritis												
Lupus												
Endocrinology												
Diabetes, Type I												
Diabetes, Type II												
Thyroid												
Orthopedic												
Congenital Hip Dysplasia												

Child's Name: ________________________ Date of Birth: _____________________

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Mom's Sister	Mom's Brother	Dad's Mom	Dad's Dad	Dad's Sister	Dad's Brother
Hematology												
Anemia												
Bleeding Disorder												
Cancer												
Immunology												
Neurology												
Headaches												
Epilepsy												
Developmental Delay												
Psychiatric												
ADD												
Depression												
Genetic												
Congenital Anomaly												
Death before age 56 for any reason not listed above												
Other												
Other												
Other												
Other												