UC Irvine Health

Pediatric Health History Form

Child's Name: ____________________________ Date: ____________________________

Primary Care Physician: ____________________

Health Concerns: __________________________

____

____

Medications/Vitamins taking: ______________

____

____

Allergies or serious reactions to Food/Medications:

____

____

Allergies or serious reactions to Vaccinations:

____

Pregnancy/Birth History

Hospital where child was born? _____________

Is child yours by: □ Birth □ Adoption □ Stepchild □ Other

Please list any medical issues during pregnancy:

□ None □ Specify: _______________

____

Delivered by: □ Vaginal Birth □ Cesarean

Premature Birth: □ No □ Yes, how early ____

Birth Weight: ________ Length: ___________

Please list any medical problems the Encountered during the first 4 weeks?

____

____

Feeding and Nutrition Information:

Child Breastfed: □ Yes □ No

If yes, how long did child breastfeed? _____

____

Any dietary or feeding issues: □ No □ Yes

Please list: ___________________________

Milk Intake:

□ Whole Cow's Milk □ 2% Cow's Milk

□ 1% Cow's Milk □ Non-fat Milk

□ Soy Milk □ Rice Milk

Average ounces per day of milk -1 cup=8oz.

____

Sleep Pattern:

Hours each night: ______________________

Naps taken: □ No □ Yes

Number of naps taken and how long?

____

Any sleep issues? ______________________

Development History:

At what age did your child: Sit _________

Walk alone ________ Say words _______

Toilet Train _______

Begin menstrual cycle _______________

Dental History:

First dental appointment: ______________

How often do you see the dentist? _______

Last dental appointment: _______________

Infectious Diseases History:
Has your child had the following diseases:
□ Chickenpox □ Mumps
□ Rubella □ Measles
□ Meningitis □ Tuberculosis (TB)

Did you bring your child's immunization record for today's visit? □ Yes □ No

Exposure to Chemicals:
Exposure to: □ Lead □ Paint
Exposure to smokers: □ No □ Yes

Television/Computer Use:
Time watching TV per day: ______________
Computer: ____________________________
Video games: ___________________________

Past Medical History:
Please list any significant medical issues/problems and the approximate dates they occurred:
____
____
____

Hospitalizations: ______________________
Surgeries: ____________________________
____
Fractures/broken bones: ________________
____
____

Family History: Please indicate any family member who has the following (parent, grandparent, sibling, etc):
Alcohol abuse: _________________________
High Cholestrol: ________________________
Cancer, specify: ________________________
High Blood Pressure: ____________________
Heart Disease: __________________________
Stroke: ________________________________
Depression: ____________________________
Suicide: _______________________________
Bleeding/clot disorder: __________________
Genetic Disorder: _______________________
Asthma/COPD: __________________________
Diabetes: ______________________________
Other: ________________________________

Social History:
Child lives with: □ Mother □ Father
□ Stepmother □ Stepfather
Siblings/ages: __________________________
____
Others: _______________________________
____
Parents of child: □ Married □ Unmarried
□ Separated □ Divorced
If separated/divorced, when: ____________
Mother's Occupation: ___________________
Father's Occupation: ____________________
Child care: □ Parents □ Other - __________
Concerns regarding your child:
□ Alcohol Use □ Tobacco Use
□ Aggressive Behavior □ Depression
□ Eating □ Sexual Activity
□ Violent Behavior □ School Problems

Review of Systems:

Check any current problems:

General:
- □ Fevers/chills/sweating
- □ Recent weight gain/loss

Eyes:
- □ Squinting/crossed eyes
- □ Visual problems

Ears/Nose/Throat:
- □ Loud voice/hard of hearing
- □ Mouth breathing/snores
- □ Bad breath
- □ Chronic stuffy nose
- □ Issues with gums/teeth
- □ Frequent tonsil/ear infections

Cardiovascular:
- □ Tires easily with exertion
- □ Short of breath
- □ Fainting

Gastrointestinal:
- □ Nausea/vomiting/diarrhea
- □ Constipation
- □ Blood in stool

Blood/Lymph
- □ Bruises easily
- □ Unexplained lumps/bumps

Respiratory:
- □ Asthma □ Frequent Cough
- □ Chest Pain

Genitourinary:
- □ Bedwetting
- □ Painful urination
- □ Discharge from penis or vagina

Musculoskeletal:
- □ Muscle Pain
- □ Joint Pain

Skin:
- □ Rashes
- □ Moles with unusual shape/color

Allergy:
- □ Hay fever
- □ Itchy eyes

Neurological:
- □ Headaches
- □ Weakness
- □ Clumsiness

Psychiatric/Emotional/Developmental
- □ Speech issues
- □ Anxiety or stress
- □ Sleep issues/too much/too little
- □ Thumb sucking/bites nails
- □ Temper/jealousy
- □ Holds breath out of anger

School History:

Attends/Attended:

□ Preschool – what age: _______________

Current Grade: ________________________

Name of School: _______________________

Does your child play sports: _____________

____

Times/hours in sports each week: ________

____

School Concerns:
- □ Grades □ Behavior
- □ Concentration
- □ Relationships
  - □ Peers
  - □ Teacher