PEDIATRIC HEALTH HISTORY

(Ages 0-10)

Patient Information	**Today's Date:**
Name on insurance: Last: First:	**Name you go by:** Last: First:
Primary language: **Do you need an interpreter?**	**Preferred pharmacy:**
Date of birth:	**Pronouns:**
Sex assigned at birth: __ Male __ Female __ Intersex **Legal sex:** __ Male __ Female __ X	**Gender identity:**
Legal Guardian Name(s):	**Relationship to patient:**
Race:	**Ethnicity:**
Are you transferring care from another provider: __ Yes __ No	**If yes, name and phone of previous provider:**

What are your main reasons for coming to the clinic today: *Please note priority.* ☐ Establish primary care

_____

_____

_____

Health History

	Allergen	**Reaction**	**Severity**	**Age of onset**
__ No allergies				
__ Need epi pen				
__ See attached				

__ None

__ See attached

Medication	Dose	Frequency	Reason prescribed

__ None

__ See attached

Supplement	Dose	Frequency	Reason taking

List all known illnesses/diagnosis, major events (surgeries, hospitalizations, accidents) and imaging. If applicable, include providers name and contact information.

Diagnosis	Date	Specialist Name	Clinic Contact

Major events: surgeries, hospitalizations, accidents	Date	Imaging (x-ray, MRI, CT, ultrasound, ECG, echo, etc)	Clinic Contact

Vaccine	Date	Vaccine	Date
TDaP (tetanus, diphtheria, pertussis)		DTaP	
Rotavirus		Seasonal Flu	
Haemophilus flu		Pneumococcal	
Poliovirus		Varicella/Chicken pox	
Hep A		Hep B	
MMR (measles, mumps, rubella)		Meningococcal	
COVID		Other:	

Family Health History - (Please include cancers, hypertension, substance abuse, diabetes, cardiac diagnoses, etc)			
Relationship	**Age if living**	**Age of death**	**Medical history**
Mother			
Maternal grandmother			
Maternal grandfather			
Father			
Paternal grandmother			
Paternal grandfather			
Sibling			

Gestational History		
Please answer parent questions for the parent who birthed the child.		
Parents age during pregnancy: Number of previous pregnancies:	Birth weight: Length of labor: APGAR score:	Gestation term: __ Full __ Premature __ Late
Parent's health during pregnancy: __ Bleeding __ Nausea __ Hypertension __ Tobacco use __ Substance use __ Diabetes __ Thyroid problems __ Other	Complications: __ Birth injury __ Fever __ Blue baby __ Rash __ Jaundice __ Colic __ Cerebral palsy __ Feeding issues	Feeding __ Breastfed __ Formula fed Age began solids: First foods:
Age sitting: Age crawling:	Age walking: Age talking:	Additional info:

Social History & Safety Screening	
Who does the child live with?	Family members in the home:
Does your family have enough to eat? __ Yes __ No	Is your family in stable housing? __ Yes __ No
Do you have smoke and carbon monoxide detectors in your home? __ Yes __ No	Do you have moisture problems in your home? __ Yes __ No
Does your family have stable transportation? __ Yes __ No	Does your child experience bullying? __ Yes __ No
Exposures: __ Tobacco smoke __ Lead __ Fuel burning appliances __ Radon __ Other	Does your child use any of the following?: __ Helmets __ Seat Belts __ Car seat __ Sunscreen
Do you have guns in your home? __ Yes __ No If yes, are they safely stored? __ Yes __ No	Grade in school: Does your child attend daycare? __ Yes __ No
Does your child take naps? __ Yes __ No	Any nightmares or sleepwalking? __ Yes __ No
Any bedwetting? __ Yes __ No	Does your child co-sleep? __ Yes __ No
In the past year, how often would you estimate someone has done any of the following to your child?	
Physically hurt them	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Insulted or talked down to them	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Threatened them with physical harm	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Screamed or cursed at them	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently
Forced them to have sex	__ Never __ Rarely __ Sometimes __ Fairly often __ Frequently

Review of Systems: Please indicate if your child has experienced any of the following within the past year.

System	Symptoms			Additional information
Constitutional	__ Weight change __ Poor appetite	__ Fever __ Abnormal activity level	__ Fussy __ Fatigue	
Eyes, Ears, Nose, Mouth, Throat	__ Glasses/contacts __ Eye pain __ Blurry vision __ Eye redness __ Eye itchiness __ Eye swelling __ Eye discharge	__ Ear pain __ Ear discharge __ Hearing loss __ Sinus pressure __ Excess drooling __ Facial swelling __ Congestion	__ Sore throat __ Hoarseness __ Mouth lesions __ Foul breath __ Dental issues	Last eye exam: _____ Provider: _____ Last dental exam: _____ Provider: _____
Cardiovascular	__ Chest pain	__ Abnormal heart rate	__ Palpitations	
Chest	__ Chest lumps	__ Chest tenderness	__ Nipple discharge	
Respiratory	__ Cough __ Painful breathing	__ Wheezing __ Asthma	__ Chest tightness	
Digestive	__ Hard to swallow __ Vomiting __ Blood in stool	__ Abdomen pain __ Diarrhea __ Mucus in stool	__ Nausea __ Constipation	
Genitourinary	__ Discharge __ Frequent urination __ Genital pain __ Genital itching	__ Blood in urine __ Urinary urgency __ Genital swelling __ Genital mass	__ Painful urination __ Incontinence __ Genital redness	
Muscles and bone	__ Swelling __ Injury	__ Muscle pain __ Joint pain	__ Decreased range of motion	
Skin	__ Pain __ Flaking __ Diaper rash __ Skin growths	__ Itching __ Redness __ Hives __ Swelling	__ Dryness __ Rash __ Skin lesions __ Bruising	
Neurologic	__ Headache __ Tingling __ Dizziness	__ Numbness __ Burning __ Fainting	__ Weakness __ Shooting pain	
Psychiatric	__ Depression __ Stress __ Hyperactivity	__ Anxiety __ Low interest __ Developmental delay	__ Insomnia __ Inattention __ IEP in place	Does your child see a counselor? __ Yes __ No Provider: Does your child see a psychiatric prescriber? __ Yes __ No Provider:
Endocrine	__ Abnormal thirst	__ Temperature intolerance		
Immune system	__ Sneezing	__ Runny nose	__ Frequent illness	

Oral Health Risk Screening

This tool was developed by the American Academy of Pediatrics to aid in assessing oral health risk. It is intended to help document risk fact for cavities.

Risk Factors	Protective Factors
Primary caregiver had active tooth decay in the past 12 months __ Yes __ No	Existing dental home __ Yes __ No
Primary caregiver does not have a dentist __ Yes __ No	Drinks fluoridated water or takes fluoride tablets __ Yes __ No
Continued use of bottle or sippy cup for fluids other than water __ Yes __ No	Fluoride varnish in the past 12 months __ Yes __ No
Frequent snacking __ Yes __ No	Brushes twice daily __ Yes __ No
Special health care needs __ Yes __ No	
Medicaid eligible __ Yes __ No	