WEST VALLEY MEDICAL GROUP

Pediatric Health History Form

Child's Name: _____ Date Of Birth: _____
Child's Previous Doctor: _____
Allergies/ Reactions to Medications or Vaccines: _____
Current Medications/ Vitamins: _____
Current Problems/ Concerns: _____

Past Medical History: (*Please Check All That Apply***)**

☐ Asthma/Hay Fever/Eczema ☐ Chicken Pox ☐ RSV
☐ Broken Bones ☐ Croup ☐ Attention Problems
☐ Frequent Ear Infections ☐ Pneumonia ☐ Other_____
(Please explain any "Yes" answers)_____
☐ Hospitalizations/Surgeries (with dates): _____

Immunizations/Exposures/Habits: (Please bring a copy of your child's immunization record to all well child appointments)

Are your child's immunizations up to date? ☐Yes ☐No
Do any household members smoke? ☐Yes ☐No
Any concerns about lead exposure (old home/ plumbing/ peeling paint)? ☐No ☐Yes
TV, computers, video games: Hours per day _____
Physical activity: Hours per day _____

Pregnancy & Birth:

Any problems with the pregnancy? ☐No ☐Yes (Please explain) _____
Delivered by: ☐Vaginal Birth ☐Cesarean Birth

Family History: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions

Alcoholism _____ High cholesterol _____
Cancer (specify type) _____ High blood pressure _____
Heart disease/stroke _____ Kidney disease _____
Depression/anxiety _____ Bleeding/clotting disorder _____
Genetic Disorders _____ Asthma/COPD _____
Diabetes _____ Other _____

Social History:

Who does child live with?
☐Mom ☐Dad ☐Siblings (how many) _____ ☐Grandma ☐Grandpa ☐Other _____
The Child's parents are: ☐Married ☐Unmarried, but living together ☐Separated ☐Divorced
Does your Child attend preschool/ school? ☐No ☐Yes Any concerns at school? ☐No ☐Yes, explain_____

Review of Systems: *(Please check any current problems your child is experiencing)*

Allergy
☐ Hay fever/itchy eyes
☐ Unexplained weight loss/gain
General
☐ Fevers/chills/excessive sweating
☐ Unexplained weight loss/gain
Eyes
☐ Squinting
☐ Crossed eyes
Ears/Nose/Throat
☐ Unusual loud voice/hard of hearing
☐ Mouth breathing/snoring
☐ Frequent runny nose
☐ Bad breath
☐ Problems with teeth/gums

Respiratory
☐ Coughing/wheezing
☐ Chest pain
Cardiovascular
☐ Tires easily with exertion
☐ Shortness of breath
☐ Fainting
Gastrointestinal
☐ Nausea
☐ Constipation
☐ Blood in bowel movement
Genitourinary
☐ Bedwetting
☐ Pain with urination
☐ Discharge: penis/vagina

Neurological
☐ Headaches
☐ Weakness
Musculoskeletal
☐ Muscle/joint pain
Blood/Lymph
☐ Unexplained lumps
☐ Easy bruising/bleeding
Psychiatric
☐ Speech problems
☐ Depression
☐ Sleep issues
Skin
☐ Rashes
☐ Unusual moles