PEDIATRIC PERIODIC HEALTH HISTORY UPDATE

Patient Name: _____ Age: _____ Date of Birth: _____

Primary Care Provider (PCP): _____ Reason for today's visit: _____

Other physician's involved in my care: _____

General Health (circle): Excellent Good Fair Poor

BIRTH HISTORY:

			COMMENT
Did you have any illness or health problems during the pregnancy?	❑ No	❑ Yes	
Any problems with birth and delivery?	❑ No	❑ Yes	
Did the baby come early?	❑ No	❑ Yes	
Did the baby have problems right after birth?	❑ No	❑ Yes	
Were there any problems in the first week of life?	❑ No	❑ Yes	
Did the baby have to stay in the hospital after mother went home?	❑ No	❑ Yes	
Did you use drugs, alcohol or tobacco during your pregnancy?	❑ No	❑ Yes	
Did you have any problems breastfeeding?	❑ No	❑ Yes	
History of breech delivery?	❑ No	❑ Yes	
Did the baby receive hepatitis B immunization prior to discharge?	❑ No	❑ Yes	
Did the baby receive vitamin K shot?	❑ No	❑ Yes	
Did the baby pass the newborn hearing test?	❑ No	❑ Yes	
Did the baby pass the congenital heart disease screen?	❑ No	❑ Yes	

Delivery method? ❑ Vaginal ❑ Cesarean If Cesarean, reason: _____

Birth weight: _____ lbs _____ oz Birth length: _____ inches Gestational age: _____ weeks

MEDICAL HISTORY:

ADD/ADHD	❑	Heart murmur	❑	Pneumonia	❑
Allergies	❑	HIV/AIDS	❑	Scoliosis	❑
Asthma	❑	Inflammatory bowel disease	❑	Seizures	❑
Cancer	❑	Jaundice	❑	Sickle cell anemia	❑
Chronic encephalopathy	❑	Lead poisoning	❑	Strep throat (recurrent)	❑
Diabetes mellitus	❑	Meningitis	❑	UTI	❑
Eczema	❑	Obesity	❑	Varicella	❑
Headaches	❑	Otitis media	❑	Vision problems	❑
Hearing loss	❑	MRSA	❑	Dental problems	❑

Other Medical History: _____

SURGICAL HISTORY:

Adenoidectomy	❑	Ear tubes	❑	Lymph node biopsy	❑
Appendectomy	❑	Gastrostomy	❑	Tonsillectomy	❑
Cleft lip	❑	Heart surgery	❑	Umbilical hernia	❑
Cleft palate	❑	Inguinal hernia	❑	VP shunt	❑
Dental surgery	❑				

Other Surgical History: _____

FAMILY HISTORY:

Relationship	Name	No Known Problems	Alcohol abuse	Arthritis	Asthma	Birth defects	Cancer	COPD	Depression	Diabetes	Drug abuse	Early death	Hearing loss	Heart disease	High cholesterol	High blood pressure	Kidney disease	Learning disability	Mental illness	Developmental disability	Miscarriages	Stroke	Vision loss	Migraines	Other
Mother																									
Father																									
Sibling																									
Sibling																									
Sibling																									
Sibling																									

Was this child adopted? ❑ No ❑ Yes Family history unknown ❑

SOCIAL HISTORY:

Please list all those living in the child's home

Name	Relationship to child	DOB	Health Problems	Occupation

Are there siblings not listed? If so, please list their names, ages, and where they live: _____

_____

If mother and father are not living together, or the child does not live with parents, what is the child's custody status? __

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

_____

Has the patient ever used cigarettes or smokeless tobacco? ❑ No ❑ Yes

If yes, quantity per day _____

Does anyone in the home smoke? ❑ No ❑ Yes

Is the patient exposed to passive or "second-hand" smoke? ❑ No ❑ Yes

Any concerns that we should know about your family, your child, your child's social, school or living situation? _____

_____

_____

Patient Identification