Eau Claire Women's and Family Care, OB-GYN Clinic of Eau Claire
Divisions of OakLeaf Clinics, SC

Pediatric Health History Form

Child's Name: _____ **Date Of Birth:** _____ **Age:** _____
Parent Name: _____ **Phone:** _____
Address: _____ **Cell:** _____
_____

Child's Previous Doctor / Primary Care Provider: _____
Present Health Concerns: _____
_____
Medicines/Vitamins/Herbals: _____
Allergies/Reactions To Medicines Or Vaccinations: _____
Pregnancy & Birth:

Is this child yours by: ❑ birth ❑ adoption ❑ stepchild ❑ other _____
Please indicate any medical problems during pregnancy ❑ none ❑ specify: _____
_____
Delivery by: ❑ vaginal birth ❑ caesarian If caesarian, why? _____
Birth weight: _____ Birth length: _____ APGAR score 1 min. _____ 5 min. _____

Sleep:

Hours per night _____ Naps (number & length) _____
Any sleep problems? _____

Development:

At what age did your child: sit alone _____ walk alone _____ say words _____ toilet train (daytime) _____
Girls only: Age at first menstrual period _____

Dental History: Has child been seen by a dentist? ❑ No ❑ Yes If so, how often _____ Date of last visit _____

Immunizations/Infectious Diseases: Please bring your child's immunization records to your appointment.

Has your child had: ❑ chickenpox ❑ measles ❑ mumps ❑ rubella ❑ meningitis ❑ tuberculosis (TB)

Exposures/Habits: Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes

Do any household members smoke? ❑ No ❑ Yes

TV ---hours per day _____ Computer---hours per day _____ Video Games---hours per day _____

Past Medical History: Please describe any major medical problems and their dates
_____
_____

Hospitalizations/Operations and dates: _____
_____

Broken bones/Severe sprains: _____
_____

Family History: Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

Social History:

Birthplace_____ Current (or upcoming) grade:_____

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are the child's parents ❑ married ❑ unmarried ❑ separated ❑ divorced If divorced, when?_____

Parents' occupations: Mother _____ Father _____

Child care situation ❑ parents ❑ others (specify who and hours per day)_____

Concerns about your child: ❑ Alcohol use ❑ Tobacco ❑ Sexual Activity ❑ Aggressive Behavior

Is violence at home a concern? ❑ No ❑ Yes Are there guns in the home? ❑ No ❑ Yes

School History:

Did/does your child attend preschool? ❑ No ❑ Yes Current grade_____ Name of school_____

Any concerns about school performance? _____

Any concerns about relationships with: Teachers ❑ No ❑ Yes____

Students ❑ No ❑ Yes _____

If over 4 years old does your child have a best friend? ❑ No ❑ Yes

Sports / exercise: Type_____ How often?_____ How long (minutes) _____

Review of Organ Systems: If child has more than one symptom on a line, circle the relevant one(s).

Constitutional / Endocrine
- ❑ Fevers/chills/excessive sweating
- ❑ Unexplained weight loss / gain

Eyes
- ❑ Squinting/"crossed" eyes/ gaze

Ears / Nose / Throat
- ❑ Unusually loud voice/hard of hearing
- ❑ Mouth breathing/snoring
- ❑ Bad breath
- ❑ Frequent runny nose
- ❑ Problems with teeth/gums
- ❑ Cough/wheeze

Gastrointestinal
- ❑ Nausea/vomiting/diarrhea
- ❑ Constipation
- ❑ Blood in bowel movement

Cardiovascular
- ❑ Tires easily with exertion
- ❑ Shortness of breath
- ❑ Fainting

Genitourinary
- ❑ Bedwetting
- ❑ Pain with urination
- ❑ Discharge: penis or vagina

Neurological
- ❑ Headaches
- ❑ Weakness
- ❑ Clumsiness

Muscular / Skeletal
- ❑ Muscle/joint pain

Allergy
- ❑ Hayfever/itchy eyes

Skin
- ❑ Rashes
- ❑ Unusual moles asymmetric

Psychiatric / Emotional
- ❑ Speech Problems
- ❑ Anxiety/stress
- ❑ Problems with sleep/ nightmares
- ❑ Depression
- ❑ Nail biting/thumbsucking
- ❑ Bad temper/breath holding/ Respiratory jealousy

Blood / Lymph
- ❑ Unexplained lumps
- ❑ Easy bruising/bleeding