CHKDHS MEDICAL GROUP
PEDIATRIC PATIENT HEALTH HISTORY

Child's Name _____ Date of Birth _____ Chart # (*Internal Use*) _____
Child's Previous Doctor / Primary Care Provider: _____

PREGNANCY & BIRTH

Birth Weight _____ lbs ____ozs Birth Length: _____ APGAR score 1 min____ 5 min.____
The child's biological status: ☐ Birth ☐ Adoption ☐ Stepchild ☐ other:_____
Delivery by: ☐ vaginal birth ☐ caesarian If caesarian, why? _____
Any related complications: ☐ None ☐ Pregnancy ☐ Labor ☐ Delivery ☐ Nursery

GENERAL

Place of Birth: _____ _____ Are the child's parents: ☐ married ☐ unmarried ☐ divorced ☐ separated
Has the child had: ☐ chickenpox ☐ measles ☐ mumps ☐ rubella ☐ meningitis ☐ tuberculosis
Do any of the child's caretakers smoke? ☐ Yes ☐ No If so, whom?_____
TV (hours per day)_____ Computer/Video Games (hours per day) _____
Any repeated illness? ☐ Yes ☐ No _____ Any surgery? ☐ Yes ☐ No _____
Any serious injury? ☐ Yes ☐ No _____ Been hospitalized? ☐ Yes ☐ No _____
Reaction to any medication? ☐ Yes ☐ No _____ School or Learning problems? _____

FAMILY HISTORY

Please fill in the following information about family members living in the home:

Name	Relationship	Date of Birth	Gender	Health Comments

Please check any family history of the conditions listed below. In addition to immediate family, include: Uncles, Aunts, and Grandparents associated with the condition.

Asthma	☐ Yes ☐ No	Alcoholism/Drug Abuse	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Birth Defects	☐ Yes ☐ No	Blood Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Genetic	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Migraines	☐ Yes ☐ No	Nerve/Muscular	☐ Yes ☐ No	Psych. Disorders	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		

Please indicate relative with condition(s):_____

PATIENT'S HISTORY: Please check if your child has had any of the following:

Allergy: ☐ Medications _____ ☐ Hayfever or itchy eyes
Blood / Lymph: ☐ Unexplained lumps ☐ Easily bruises or bleeds ☐ Anemia ☐ High blood pressure
Cardiovascular: ☐ Easily tires ☐ Shortness in breath ☐ Fainting ☐ Heart disease or murmur
Constitutional / Endocrine: ☐ Fevers/chills ☐ Excessive sweating ☐ Weight loss or gain
Eyes: ☐ Disease/injury ☐ Squinting ☐ Crossing Eyes ☐ Gazing
Ear/Nose/Throat: ☐ Congestion ☐ Difficulty hearing ☐ Mouth Breathing/snoring ☐ Bad breath ☐ Frequent runny nose
☐ Problems with teeth/gums (sores)
Gastrointestinal: ☐ Nausea/diarrhea ☐ Constipation ☐ Blood in bowel movement ☐ Abnormal thirst/appetite
Genitourinary: ☐ Bedwetting ☐ Frequent/painful urination ☐ Discharge: penis or vagina
Muscular/Skeletal: ☐ Muscle/joint pain ☐ Spine curvature
Neurological: ☐ Headaches ☐ Weakness ☐ Clumsiness
Psychiatric: ☐ Speech problems ☐ Anxiety/Stress ☐ Trouble sleeping ☐ Depression ☐ Behavior
Respiratory: ☐ Prolonged coughing ☐ Wheezing
Skin: ☐ Burns ☐ Birthmarks ☐ Disease ☐ Rashes ☐ Unusual moles