Heart to Heart Pediatrics

Pediatric History Form

Name:_____DOB:_____ ☐MALE ☐FEMALE
Mother's Name:_____ Age_____ Father's Name _____ Age_____
Does your child have any Allergies (medication, food, etc.)? _____

BIRTH HISTORY

Birth weight _____ Preg # _____Mom's age_____
Was the baby born on time? _____ Early? _____Late_____
If early, how many weeks gestation? _____
Did mother have any illness or problems during pregnancy? ☐Y ☐N
Explain_____
During pregnancy, did mother:
Smoke ☐Y ☐N Drink alcohol ☐Y ☐N
Use drugs or medication ☐Y ☐N

Was the delivery ☐Vaginal? ☐Cesarean?
If Cesarean, why?_____
Did your baby have any problems right after birth? ☐Y ☐N
Explain_____
_____
What was the initial feeding ☐Breast Milk? ☐Formula?
Did the baby go home with mother from hospital? ☐Y ☐N
Explain_____

HOUSEHOLD INFORMATION

Is child in day care? ☐Y ☐N Smokers in the household? ☐Y ☐N Pets in the household? ☐Y ☐N
Are there any siblings not listed? If so, please list their names and ages and where they live. _____
_____
If mother and father are not living together or if 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? _____
_____

CURRENT AND PAST HISTORY

What medication does your child currently take? _____
_____
Has your child ever been prescribed an Inhaler or given breathing treatments: ☐Y ☐N
Does your child have or has had any of the following

Asthma	☐Y	☐N	Heart murmurs	☐Y	☐N	Kidney or bladder infection	☐Y	☐N
Allergies	☐Y	☐N	Eczema	☐Y	☐N	Anemia	☐Y	☐N
Diabetes	☐Y	☐N	Chronic constipation	☐Y	☐N	Frequent ear infections	☐Y	☐N
Autism	☐Y	☐N	Hearing Problem	☐Y	☐N	Chronic abdominal pain	☐Y	☐N
School Problems	☐Y	☐N	Frequent headaches	☐Y	☐N	Developmental Delays	☐Y	☐N
ADD	☐Y	☐N	Mental Health issues	☐Y	☐N	Reaction to vaccines	☐Y	☐N

Other_____

Has your child been hospitalized? ☐Y ☐N
Date: Reason:
_____ _____
_____ _____
_____ _____

Has had any surgeries? ☐Y ☐N
Date: Reason:
_____ _____
_____ _____
_____ _____

Does your child see any specialist? If so please list the name of the Doctor and reason for visit
Dr. Name: _____ Reason: _____
Dr. Name: _____ Reason: _____
Dr. Name: _____ Reason: _____
How does your child do in school? _____
_____
Do you have any other issues or concerns not listed above? _____

FAMILY MEDICAL HISTORY

Has any family member had the following:

Alcohol/Drug abuse	☐Y	☐N	Allergies	☐Y	☐N	Arthritis	☐Y	☐N
Anesthesia Risk	☐Y	☐N	Blood Disease	☐Y	☐N	High Cholesterol	☐Y	☐N
High Blood Pressure	☐Y	☐N	Cancer	☐Y	☐N	Heart Disease	☐Y	☐N
Diabetes	☐Y	☐N	SIDS	☐Y	☐N	Hearing Loss	☐Y	☐N
Developmental Delay	☐Y	☐N	Autism	☐Y	☐N	Depression	☐Y	☐N
Bipolar	☐Y	☐N	Schizophrenia	☐Y	☐N	Stroke	☐Y	☐N
Negative family history	☐Y	☐N	ADD	☐Y	☐N	Thyroid	☐Y	☐N

Additional family history/comments: _____

_____ _____
Parent/Guardian Signature: Date: