WHITE OAK PEDIATRICS ASSOCIATES P.A.
4414 LAKE BOONE TRAIL, SUITE 103
RALEIGH, NC 27607
PHONE: (919) 787-0266

Date: _____

PEDIATRIC HEALTH HISTORY ASSESSMENT

Name: _____ Nickname/Preferred Name: _____

Date of Birth: _____

List Allergies (Medicine, Food, Hayfever, Latex, etc.)/Reactions: _____

_____

_____

Current Medications/Vitamins/Supplements (List any that he/she may be taking.)

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

Family History: (Relative)

- ☐ Allergies
- ☐ Asthma
- ☐ TB
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Sickle Cell
- ☐ Mental Illness
- ☐ Sudden Death
- ☐ Known Inheritable Conditions/Diseases
- ☐ Suicide
- ☐ Alcoholism

Childhood Illness:

- ☐ Chickenpox
- ☐ Broken Bones
- ☐ Headaches
- ☐ Seizures
- ☐ Pneumonia
- ☐ Hospitalization: _____
- ☐ Asthma/Wheezing
- ☐ Frequent Ear Infections
- ☐ Mental Illness
- ☐ Congenital Abnormalities

	YES	NO	COMMENTS
1. Any problems with pregnancy?	☐	☐	_____
Length of pregnancy_____ ☐ Early ☐ On time ☐ Late ☐ C-section ☐ Induced			
2. Any problems with labor?	☐	☐	_____
3. Any problems during delivery?	☐	☐	_____
4. Birth weight? _____	☐	☐	_____
5. Any problems in first month of life?	☐	☐	_____
6. Has he/she been hospitalized?	☐	☐	_____
7. Has he/she had any surgery/operations?	☐	☐	_____
8. Has he/she had a serious accident?	☐	☐	_____
9. Has he/she had any broken bones?	☐	☐	_____
10. Has he/she failed any grades?	☐	☐	_____
11. Has he/she experienced any problems in school?	☐	☐	_____
12. Any firearms in the house?	☐	☐	_____
13. Does he/she drink well water?	☐	☐	_____
14. Any exposure to lead?	☐	☐	_____
15. Smokers in the home?	☐	☐	_____
16. Pets in the home?	☐	☐	

DEVELOPMENTAL: Please complete this section for children 6 years of age and under.
List approximate ages at which your child first accomplished the following:

Rolled Over _____ Crawled _____ Said First Sentences _____ Climbed Stairs _____
Sat Up _____ Walked Alone _____ Said Sentences _____ Toilet Trained _____

– OVER –

PEDIATRIC HEALTH HISTORY ASSESSMENT (Cont.)

NUTRITIONAL

Diet: Type: _____ ☐ Special Formula/Diet Needs

Comments: _____

☐ Feeds Self ☐ Needs Assistance with Meals ☐ Needs to be Fed ☐ Table Foods ☐ Baby Foods ☐ Cup

☐ Bottle ☐ Breast Feeding Comments: _____

ACTIVITY/EXERCISE

☐ Walks Alone ☐ Walks with Assistance ☐ Stands Alone ☐ Sits Alone ☐ Assistive Devices _____

Limitations ☐ None ☐ Yes: _____

Weaknesses ☐ None ☐ Yes: _____

Joint Problems ☐ None ☐ Yes: _____

SLEEP/REST

☐ Sleeps Alone ☐ Sleeps through Night Naptime: _____ Bedtime: _____

Any Sleep Pattern Changes ☐ No ☐ Yes

COGNITIVE/PERCEPTUAL

Developmental Level: Normal for Age ☐ Yes ☐ No Primary Language: _____

☐ Right Handed ☐ Left Handed ☐ Reads ☐ Writes

Difficulty With: Speech: ☐ No ☐ Yes: _____

Hearing: ☐ No ☐ Yes: _____ ☐ Aids ☐ R ☐ L ☐ Signs ☐ Cued ☐ Reads Lips

Vision: ☐ No ☐ Yes: _____ ☐ Glasses ☐ Contacts

If communication is difficult, how do we best communicate? _____

ROLE/RELATIONSHIP

Legal Guardian: _____ Lives With: _____

Mother's Last Name: _____ Education: _____

Father's Last Name: _____ Education: _____

☐ Stays at Home ☐ Day Care ☐ School/Grade: _____ # of Siblings in Household: _____

Parents: ☐ Married ☐ Single ☐ Single Divorced ☐ Separated

VALUES/BELIEFS

Religion: _____

Special Request Due to Religious Practices/Values: _____

_____

Completed By: _____ Relationship to Patient: _____