Carolinas HealthCare System

NEW PEDIATRIC PATIENT HEALTH HISTORY FORM

Child's Name:		**Date:**
Primary Care Provider:	Age	DOB
Allergies/Reactions:***		
Please list any present health concerns:	List any medications your child takes daily***	Herbs/home remedies used?

PREGNANCY AND BIRTH* **	
1.	Is your child: ☐ Birthed ☐ Adopted ☐Stepchild Other:
2.	Any medical problems during pregnancy?: ☐ No ☐ Yes, Specify:
3.	Delivered by: ☐ Vaginal Birth ☐ Caesarean, why:
4.	Birth Weight: lbs: oz Birth Length inches
5.	Please indicate any medical problems during the baby's newborn period: ☐ None ☐ Premature weeks:
Other problems:	
NUTRITION AND FEEDING	
1.	Was your child breastfed? ☐ No ☐ Yes, how long?
2.	Any unusual feeding/dietary concerns? ☐ No ☐ Yes, specify:
3.	Milk intake currently: ☐ Cow milk (non-fat, 1% fat, 2% fat, whole milk) ☐ Soy milk ☐Rice milk
Average ounces per day (Note: 8 ounces are in 1 cup):	
SLEEP	
Hours of sleep per night: Naps (number and length):	
Any sleep problems: ☐ No ☐ Yes, explain:	
DEVELOPMENT	
What age did you child: Sit alone: Walk alone: Say words: Toilet train:	
If applicable: Age at first menstrual cycle:	
DENTAL HISTORY	
Has child been seen by a dentist? ☐ No ☐ Yes, how often: Last visit date:	
IMMUNIZATIONS/INFECTIOUS DISEASES: ***Please bring your child's immunization records to your appointment.***	
Has your child had chickenpox ☐ No ☐ Yes Chickenpox Vaccine ☐ Yes ☐ No	

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: ***	

FAMILY HISTORY **Please check off any family history of the following (indicate who has/had the condition)**

☐ Alcoholism/Drug Abuse	☐ Heart disease or Stroke before 60	☐ Inherited/Genetic Diseases
☐ High Blood Pressure	☐ Thyroid Disease	☐ Psychiatric Disorders
☐ Asthma/Hay Fever/Eczema	☐ Bleeding/Clotting Problems	☐ Seizures

☐ Kidney Disease ☐ Birth Defects ☐ Other

Social History ***	Birthplace:	Current (or upcoming) grade:

Child lives with:

Name:	Age:	Relationship:	Education level:
Name:	Age:	Relationship:	Education level:
Name:	Age:	Relationship:	Education level:
Name:	Age:	Relationship:	Education level:
Name:	Age:	Relationship:	Education level:

Are the child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced, when?

Parent's Occupation: Mother: Father:

Child care situation ☐ Parents ☐ Daycare ☐ Other 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

Any concerns about relationships with: Teachers ☐ No ☐ Yes, explain:
Students ☐ No ☐ Yes, explain:

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: PLEASE CIRCLE ANY THAT ARE RELEVENT

Constitutional/Endocrine *Fevers/chills/excessive sweating *Unexplained weight loss/gain	Gastrointestinal *Nausea/vomiting/diarrhea *Constipation *Blood in bowel movement	Allergy *Hay fever *Itchy eyes

Eyes *Squinting/"crossed" eyes *Asymmetric gaze	Cardiovascular *Tires easily with exertion *Shortness of breath *Fainting	Skin *Rashes *Unusual moles	Muscular *Joint pain

Ears/Nose/Throat *Unusually loud voice/hard of hearing *Mouth breathing/snoring *Bad breath *Frequent runny nose *Problems with teeth/gums	Genitourinary *Bedwetting *Pain with urination *Discharge: penis or vagina	Psychiatric *Speech problems *Anxiety/Stress *Problems with sleep/nightmares *Depression *Nail biting/thumb sucking *Bad temper/breath holding/jealousy

Respiratory *Cough/wheeze	Neurological *Headaches *Weakness *Clumsiness	Blood/Lymph *Unexplained lumps *Easy bruising/bleeding