

North Texas Medical-Surgical Clinic

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Denton, Texas 76201
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Family Medicine
Internal Medicine
Sports Medicine

Pediatric Health History Form

Child's Name: _____ Date of Birth: _____ Age: ____

Child's Previous Doctor: _____

Medications and Dose (including vitamins and herbal / alternative treatments):

Allergies or Reactions to Medicines or Vaccines:

Pregnancy & Birth:

Where was your child born?

Is the child yours by: ___ Birth ___ Adoption ___ Stepchild ___ Other: _____

Were there any medical problems during pregnancy, if any: _____

Delivery by: ___ Vaginal ___ Caesarian If Caesarian, Why?

Birth weight: _____ Birth length: _____

Were there any medical problems during the baby's newborn period? ___ Yes ___ No

If yes, please specify:

If premature, how early?

Nutrition & Feeding:

Was your child breastfed? ___ Yes ___ No If yes, how long? _____

Has your child had any feeding or dietary problems? ___ Yes ___ No

If yes, please specify:

Sleep:

How many hours per night? _____ Naps? (number & length) _____

Does your child have any sleep problems? ___ Yes ___ No

If yes, please specify:

Development:

At what age did your child: _____ Sit alone _____ Walk alone

_____ Say words clearly _____ Toilet train _____ Dress him/herself _____ Read

Girls only: age of first menstrual period _____

Dental History:

Has your child been seen by a dentist? ___ Yes ___ No Date of last visit _____

Immunizations:

Please bring your child's immunization records to his/her appointment.

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Pediatric Health History Form

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Child's Name: _____ Date of Birth: _____ Age: ____

Past Medical History:

Please describe any major medical problems and their dates.

Has your child ever been hospitalized or had any surgeries? If yes, please describe.

Family Health Information:

Please circle the disease if anyone in your child's family has these diseases and write your child's relationship to that person.

	<u>Relationship</u>		<u>Relationship</u>
Asthma		High blood pressure	
Cancer		Kidney disease	
High cholesterol		Heart attack before age 65	
Adult onset diabetes		Childhood onset diabetes	
Alcohol or drug abuse		Stroke	
Seizures		Thyroid disease	
Sudden unexplained death		Sickle cell trait	
Genetic disorder		Depression	
Mental Illness		Other: _____	

Social History:

Who lives at home?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>

_____ Who are your child's primary caregivers?

_____ Are your child's primary caregivers
___ Married ___ Divorced/Separated ___ Unmarried ___ Partnered ___ Other

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Pediatric Health History Form

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Child's Name: _____ Date of Birth: _____ Age: ___

Exposures:

Do any household members smoke? ___ Yes ___ No
Concerns about lead exposure? (old home or plumbing, peeling paint) ___ Yes ___ No
Are there guns in the home? ___ Yes ___ No If yes, are they locked? ___ Yes ___ No
Are there pets at home? ___ Yes ___ No If yes, what kinds? _____
TV-hours per day _____ Computer use and video games-hours per day _____

School History:

What grade is your child in? _____, at which school?

Do you have any concerns about your child's school performance? ___ Yes ___ No
If yes, please describe

Do you have any concerns about your child's relationship with other students, or with his/her teachers? ___ Yes ___ No
If yes, please describe

Is your child involved in any sports or exercise? ___ Yes ___ No
If yes, what type? _____ How often?

Is there any other important information about your child that we missed?
If yes, please describe

Signature, and relation to

patient_____

Date:_____