PEDIATRIC
0-12

PARTNERSHIP HEALTH CENTER

Patient Name: ______________________
Date: ____________________________

HEALTH HISTORY
PAST HEALTH PROBLEMS

Please indicate if your child has had any serious illnesses or birth defects:

INJURY / ILLNESS	DATE

MEDICATIONS: ____

MEDICATION ALLERGIES:_____________________________________

HOSPITALIZATIONS/ SURGERIES

YEAR	REASON/PROCEDURE	HOSPITAL OR CITY

DOES YOUR CHILD HAVE OR HAS EVER HAD ANY OF THE FOLLOWING:

GENERAL	YES	NO	GENERAL	YES	NO
Crossed or wondering eyes			Wear glasses or contacts		
Repeated ear infections or drainage			Ear tubes		
Speech problems or speech delay			Deafness or decreased hearing		
Trouble breathing threw nose			Frequent colds or sore throat		
Recurrent strep throat			Tooth decay or tooth defects		
Acne or skin problems			Chronic cough		
Shortness of breath with activity/asthma			Positive skin test for TB (tuberculosis)		
Heart murmur			Irregular heart beat		
High blood pressure			Blood cholesterol test		
Anemia or low blood count			Chronic or frequent diarrhea		
Bowel movements in underwear			Constipation		
Recurrent vomiting			Recurrent abdominal pain		
Bedwetting or daytime wetting problems			Painful or frequent urination		
Painful or swollen joints			Problems with coordination		
Scoliosis or abnormal curvature of back			Headaches		
Loss of balance			Any bedtime or sleep problems		
Any concerns with diet or growth			Was (is) child breast feed		
Does your child currently us a bottle			Does your child take a bottle to bed		
Does your child use fluoride			Does child use vitamin supplements		

SAFETY AND HEALTH BEHAVIORS

	YES	NO		YES	NO
Does your child always use a car seat or seat belt ?			Are medications, cleaning agents and other dangerous substances kept out of child's reach?		
Do you have the number to poison control center?			Does your child know how to swim?		
Do you have stairs in your home?			Are there smoke detectors in the home?		
Do you have safety plugs in unused wall sockets?			Do you have safety gates on your stairs?		
Does your child wear sunscreen while outdoors?			Do you have any questions on child proofing your home?		
Do you know CPR?			Has your child been tested for lead poisoning?		
Are there people who smoke in your household?			Does your infant sleep on his or her back?		
Does your child brush/ floss their teeth?			Do you heat with wood?		

Date of last Dental visit:_____________________________

Family Health History

Have any immediate family members had any one the following illnesses? If so, please indicate relationship to patient (etc. mother, father, sister, brother, maternal/paternal grandparents)

High blood pressure _____________
Heart disease _________________
Eczema _________________
Cancer (type) _________________
Diabetes _________________
Asthma/ emphysema _____________
Tuberculosis _________________
Cystic fibrosis _________________
Blood disease _________________
Thyroid disease _______________

Epilepsy ____________________
Rheumatoid arthritis ____________
Kidney disease ________________
Scoliosis ____________________
Crossed/ lazy eye ______________
Mental health problems __________
High Cholesterol _______________
Hepatitis A, B, or C, ____________
Alcoholism/ drug abuse __________
Birth Defects _________________

PRENATAL HISTORY

Did you have prenatal care? YES ____NO_____
Did you use any prescription drugs during pregnancy? YES____NO____
If so, please list ____
Did you smoke or use alcohol during your pregnancy? YES___NO____
If so, how often _________ and how much______________
Was your baby born between 36 and 40 weeks? YES____ NO_____
How many much did your baby weigh at birth _____pounds ______ounces?
Were there any complications during the first week of life? YES____NO____
If so, what were they?____

Do you have any other concerns we are unaware of that needs to be addressed today?

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