



Pediatrics History Form

De	ear Parent:									
		estionnaire o	n your child. Please c	complete thi	s form. Bring	it with you at th	e time o	of an appointm	ent.	
	ite completed:									
						Date of	Birth_			
	ntact Information									
Hc	me Phone		Woi	rk Phone			Cell P	hone		
	ntact Information									
Ad	ldress				City			_ State	Zip_	
Hc	me Phone		Woi	rk Phone			Cell P	hone		
	is child lives with				.	7				
	_] Father	☐ Mother/Father	∐ Moth	er/Partner		atner	☐ Grandpa	arent/Other	
	T Affilition		D :::			5				
			Position			Depart	ment_			
Fa	amily Histor	y								
1.	Parent 1	Age	e	Currer	nt Health					
	Past Hea	alth Problems	S							
2.			e							
			sEducation/Training							
3.										
	Other Children									
Date of Birth Gender		Gender	Name		Healthy or Medical Issues?					
_										
5.	Are there cult	ural or religio	us practices that mig	ıht affect yo	ur child's med	dical care?			no	☐ yes
lf y	es, please expl	ain (e.g. blood	d transfusion, dietary	rules, etc.): _						
6.	Is there tobac	cco use in/arc	ound your household	?					☐ no	☐ yes

Pediatric Patient Health HistoryV 01-12-24Page 1 of 6

Is there a history in the family/a blood relative of: If yes, state relationship to child a. Allergies ☐ no yes **b.** Anxiety ☐ no ☐ yes c. Asthma ☐ no ☐ yes d. Birth Defects/Genetic Problems ☐ yes ☐ no e. Cancer ☐ no ☐ yes i. Brain ☐ no ☐ yes ii. Breast ☐ no ☐ yes iii. Colon ☐ no ☐ yes iv. Ovarian ☐ no ☐ yes v. Skin ☐ no ☐ yes vi. Thyroid ☐ no ☐ yes vii. Vii. Other (describe and state relationship to child): **f.** Depression ☐ no ☐ yes g. Diabetes ☐ no ☐ yes h. Hearing Loss ☐ no ☐ yes i. Heart Attack ☐ no ☐ yes j. Heart Disease ☐ no ☐ yes k. Hepatitis ☐ no ☐ yes I. High Blood Pressure ☐ no ☐ yes m. High Cholesterol ☐ no ☐ yes n. Learning Disability ☐ no ☐ yes o. Mental Illness ☐ no ☐ yes **p.** Seizures ☐ no yes q. Thyroid Problems ☐ no ☐ yes r. Tuberculosis ☐ no ☐ yes **Prenatal History** 8. While pregnant, did mother have: ☐ no ☐ yes a. Bleeding or spotting \square no ☐ yes **b.** German measles (Rubella) ☐ no ☐ yes c. Gestational diabetes ☐ no ☐ yes d. High blood pressure no no ☐ yes e. Illness other than cold/flu no no ☐ yes f. Kidney disease ☐ no ☐ yes g. Premature labor no no ☐ yes h. Threatened miscarriage \square no ☐ yes i. Toxemia □ no ☐ yes **9.** Were medications or herbs taken during pregnancy?: ☐ no ☐ yes If yes, what kind **10.** Was a fertility treatment used for this pregnancy? ☐ no ☐ yes

Pediatric Patient Health History Page 2 of 6

If yes, what kind

Birth His	story
-----------	-------

12. 13. 14. 15. 16.	Where was child born: Was labor induced? Was labor helped by medication? Duration of labor: Was child born early (less than 38 weeks) Was child born late (after 42 weeks)? What was the method of delivery: Breech Caesarean (Please state reason)		no	yes yes yes yes yes yes
	orceps			
	Spontaneous vaginal			
	A := === (:f1:=====)			
	During the hospital stay, did child have an	nv of the followina:		
	Antibiotic treatment	, , , , , , , , , , , , , , , , , , , ,	no	☐ yes
k	b. Blue spells		no no	☐ yes
c	Convulsions	□ no	☐ yes	
c	I. Jaundice	no no	☐ yes	
e	s. Skin rash	no no	☐ yes	
f	. Did child remain in hospital longer than	mother?	no no	☐ yes
21.	How was/is baby fed?			
	Bottle			
	Breast			
De	velopmental History			
22.	At what age did child:	Age		
a	. Hold up head		_	
k). Roll over		_	
C	Sit unsupported		_	
C	I. Stand alone		_	
e	e. Walk		_	
f	. Talk		_	
	J. Toilet train		_	
	. Feed him/herself		_	
i.	. Dress him/herself			

Immunizations

PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES And TB (Tuberculosis) Testing or BCG Vaccination

Pediatric Patient Health HistoryV 01-12-24Page 3 of 6

Past Medical History

23. Has the child had			
a. Blood: anemia (iron deficiency, Sickle Cell, Thalessemia)		☐ no	☐ yes
b. Blood transfusions		☐ no	☐ yes
c. Chicken pox (Varicella)		☐ no	☐ yes
d. Contusions		☐ no	☐ yes
e. Convulsions		☐ no	☐ yes
f. Fractures		☐ no	☐ yes
g. German Measles (Rubella)		☐ no	☐ yes
h. Hospitalizations		☐ no	☐ yes
i. Measles (Rubeola)		☐ no	☐ yes
j. Meningitis		☐ no	☐ yes
k. Mumps		☐ no	☐ yes
I. Operations		☐ no	☐ yes
If yes, what kind			
m. Poison ingestion		□no	☐ yes
n. Other serious medical illnesses		☐ no	☐ yes
If yes, what kind			
o. Is your child currently taking any medications, vitamins or herbs?		☐ no	☐ yes
Medication Strength/Dose	How Often		
p. Reaction to medication or food (allergy)		no	☐ yes
If yes, please explain			
q. Any chronic or recurring pain?		□no	☐ yes
If yes, please explain			
24. Eyes			
a. Any visual problems?		☐ no	☐ yes
b. Do eyes look crossed?		☐ no	☐ yes
c. Does the child wear eyeglasses?		☐ no	☐ yes
25. Ears			
a. Any hearing problems?		☐ no	☐ yes
b. Three or more ear infections?		☐ no	☐ yes
26. Nose			
a. Does the child have frequent attacks of sneezing or rubbing his/her nose?		☐ no	☐ yes
b. Has the child had frequent nose bleeds?		☐ no	☐ yes
27. Throat			:
a. Does your child have three or more strep throat infections per year?	☐ no	☐ yes	

Pediatric Patient Health HistoryV 01-12-24Page 4 of 6

Have you ever been told your child has	28. Heart		
b. Heart defect?	Have you ever been told your child has		
C. Highblood pressure?	a. A heart murmur?	□ no	☐ yes
29. Lungs Has your child ever had a. A sthrma/wheezing? no yes b. Bronchilts or pneumonia? no yes c. Chronic cough? 30. Does your child it easily? 31. Abdomen Has your child ever had a. Blood in bowel movement? no yes b. Difficulty with appetite or eating? no yes c. Frequent abdominal pain? no yes d. Frequent wornting or diarrhea? no yes e. Jaundice? no yes f. Marked weight loss? no yes lyes, please explain yes 32. Kidney no yes a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child ever complain of burning or frequency of urination? no yes b. Does your child ever had a urinary tract infection? no yes d. Has your child ever had a urinary tract infection? no yes 34. Extremities no yes Has your child ever had no yes b. A persistent limp? no yes b. A persistent limp? no yes b. A persistent limp? no yes <t< td=""><td>b. Heart defect?</td><td>no</td><td>☐ yes</td></t<>	b. Heart defect?	no	☐ yes
Has your child ever had a. Asthma/wheezing?	c. High blood pressure?	☐ no	☐ yes
a. Asthma/wheezing? no yes b. Bronchitis or pneumonia? no yes c. Chronic cough? no yes 30. Does your child tire easily? 31. Abdomen Has your child ever had no yes a. Blood in bowel movement? no yes b. Difficulty with appetite or eating? no yes c. Frequent abdominal pain? no yes d. Frequent wornting or diarrhea? no yes e. Jaundico? no yes f. Marked weight loss? no yes f. Marked weight loss? no yes g. Does your child ever complain of burning or frequency of urination? no yes a. Does your child ever befole on yes he has your child ever had a urinary tract infection? no yes 33. Skin no yes he Arny sensitivity or allorgy? no yes a. Acne? no yes he Arny sensitivity or allorgy? no yes b. A persistent limp? no yes he Apersistent limp? no yes b. A persistent limp? no yes he Xernemities no yes 5. Neurological no yes he Xernemities no yes	29. Lungs		
b. Bronchitis or pneumonia?	Has your child ever had		
C. Chronic cough?	a. Asthma/wheezing?	no	☐ yes
30. Does your child tire easily? 31. Abdomen Has your child ever had a. Blood in bowel movement? no yes b. Difficulty with appetite or eating? no yes c. Frequent abdominal pain? no yes d. Frequent vomiting or diarrhea? no yes e. Jaundice? no yes f. Marked weight loss? no yes f. Marked weight loss? no yes f. Syour child ever complain of burning or frequency of urination? no yes a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child ever ben blood in the urine? no yes d. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Ezczema or atopic dermatitis? no yes 34. Extremities Has your child a. Had weakness or paralysis of arms or legs? no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological </td <td>b. Bronchitis or pneumonia?</td> <td>☐ no</td> <td>☐ yes</td>	b. Bronchitis or pneumonia?	☐ no	☐ yes
31. Abdomen Has your child ever had a. Blood in bowel movement? no ges b. Difficulty with appetite or eating? no ges c. Frequent abdominal pain? no ges d. Frequent vomiting or diarrhea? no ges e. Jaundice? no ges f. Marked weight loss? no ges If yes, please explain 32. Kidney a. Does your child ever complain of burning or frequency of urination? no ges b. Does your child wet the bed? no ges c. Has there ever been blood in the urine? no ges d. Has your child ever had a urinary tract infection? no ges 33. Skin no ges a. Acne? no ges b. Any sensitivity or allergy? no ges c. Ezczema or atopic dermatitis? no ges 34. Extremities Has your child no ges b. A persistent limp? no ges c. Every worn corrective shoes or braces? no ges 35. Neurological Has your child ever had a. Breath holding? no ges b. Convulsions or seizures? no ges c. Dizziness?	c. Chronic cough?	☐ no	☐ yes
A. Blood in bowel movement?	30. Does your child tire easily?		
a. Blood in bowel movement? no yes b. Difficulty with appetite or eating? no yes c. Frequent abdominal pain? no yes d. Frequent vomiting or diarrhea? no yes e. Jaundice? no yes f. Marked weight loss? no yes If yes, please explain 32. Kidney a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child wet the bed? no yes c. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Eczema or atopic dermatitis? no yes 34. Extremities no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological Has your child ever had a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches?<	31. Abdomen		
b. Difficulty with appetite or eating? □ no □ yes c. Frequent abdominal pain? □ no □ yes d. Frequent vomiting or diarrhea? □ no □ yes e. Jaundice? □ no □ yes f. Marked weight loss? □ no □ yes if yes, please explain □ no □ yes 32. Kidney □ no □ yes a. Does your child ever complain of burning or frequency of urination? □ no □ yes b. Does your child wet the bed? □ no □ yes c. Has there ever been blood in the urine? □ no □ yes d. Has your child ever had a urinary tract infection? □ no □ yes 33. Skin □ no □ yes a. Acne? □ no □ yes b. Any sensitivity or allergy? □ no □ yes c. Ezzema or atopic dermatitis? □ no □ yes 34. Extremities □ no □ yes 4a. Had weakness or paralysis of arms or legs? □ no □ yes b. A persistent limp? □ no □ yes c. Every worn corrective shoes or braces? □ no □ yes 35. Neurological □ no □ yes that your child ever had □ no □ yes a. Breath holding? □ no □ yes <	Has your child ever had		
c. Frequent abdominal pain? no yes d. Frequent vomiting or diarrhea? no yes e. Jaundice? no yes f. Marked weight loss? no yes If yes, please explain yes 32. Kidney no yes a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child wet the bed? no yes c. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Eczema or atopic dermatitis? no yes 34. Extremities Has your child a. Had weakness or paralysis of arms or legs? no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological Has your child ever had a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes	a. Blood in bowel movement?	☐ no	☐ yes
d. Frequent vomiting or diarrhea? no yes e. Jaundice? no yes f. Marked weight loss? no yes If yes, please explain 32. Kidney a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child wet the bed? no yes c. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Ezcema or atopic dermatitis? no yes 34. Extremities a. Had weakness or paralysis of arms or legs? no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological no yes Has your child ever had no yes a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e.	b. Difficulty with appetite or eating?	☐ no	☐ yes
e. Jaundice? no yes f. Marked weight loss? no yes If yes, please explain no yes 32. Kidney no yes a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child wet the bed? no yes c. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Ezema or atopic dermatitis? no yes 34. Extremities a. Had weakness or paralysis of arms or legs? no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes	c. Frequent abdominal pain?	☐ no	☐ yes
f. Marked weight loss? no yes If yes, please explain 99 32. Kidney no yes a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child wet the bed? no yes c. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Eczema or atopic dermatitis? no yes 34. Extremities Has your child Has your child no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological Has your child ever had a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes			-
If yes, please explain			
32. Kidney a. Does your child ever complain of burning or frequency of urination? b. Does your child wet the bed? c. Has there ever been blood in the urine? d. Has your child ever had a urinary tract infection? 33. Skin a. Acne? b. Any sensitivity or allergy? c. Eczema or atopic dermatitis? 34. Extremities Has your child a. Had weakness or paralysis of arms or legs? b. A persistent limp? c. Every worn corrective shoes or braces? 35. Neurological Has your child ever had a. Breath holding? b. Convulsions or seizures? c. Dizziness? d. Fainting? e. Frequent headaches?	f. Marked weight loss?	☐ no	☐ yes
a. Does your child ever complain of burning or frequency of urination? no yes b. Does your child wet the bed? no yes c. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Eczema or atopic dermatitis? no yes 34. Extremities Has your child no yes a. Had weakness or paralysis of arms or legs? no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological Has your child ever had a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no no yes	If yes, please explain		
b. Does your child wet the bed? □ no □ yes c. Has there ever been blood in the urine? □ no □ yes d. Has your child ever had a urinary tract infection? □ no □ yes 33. Skin □ no □ yes a. Acne? □ no □ yes b. Any sensitivity or allergy? □ no □ yes c. Eczema or atopic dermatitis? □ no □ yes 34. Extremities □ no □ yes Has your child □ no □ yes a. Had weakness or paralysis of arms or legs? □ no □ yes b. A persistent limp? □ no □ yes c. Every worn corrective shoes or braces? □ no □ yes 35. Neurological □ no □ yes Has your child ever had □ no □ yes a. Breath holding? □ no □ yes b. Convulsions or seizures? □ no □ yes c. Dizziness? □ no □ yes d. Fainting? □ no □ yes e. Frequent headaches? □ no □ yes	32. Kidney		
c. Has there ever been blood in the urine? no yes d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Eczema or atopic dermatitis? no yes 34. Extremities Has your child no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological Has your child ever had no yes a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes		☐ no	☐ yes
d. Has your child ever had a urinary tract infection? no yes 33. Skin no yes a. Acne? no yes b. Any sensitivity or allergy? no yes c. Eczema or atopic dermatitis? no yes 34. Extremities Has your child no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological Has your child ever had a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes			
33. Skin a. Acne? no ges b. Any sensitivity or allergy? no ges c. Eczema or atopic dermatitis? no ges 34. Extremities Has your child a. Had weakness or paralysis of arms or legs? no ges b. A persistent limp? no ges c. Every worn corrective shoes or braces? no ges 35. Neurological Has your child ever had a. Breath holding? no ges b. Convulsions or seizures? no ges c. Dizziness? no ges d. Fainting? no ges e. Frequent headaches? no ges			
a. Acne? no yes b. Any sensitivity or allergy? no yes c. Eczema or atopic dermatitis? no yes 34. Extremities Has your child a. Had weakness or paralysis of arms or legs? no yes b. A persistent limp? no yes c. Every worn corrective shoes or braces? no yes 35. Neurological Has your child ever had a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes		no no	☐ yes
b. Any sensitivity or allergy?		_	_
c. Eczema or atopic dermatitis?			
34. Extremities Has your child a. Had weakness or paralysis of arms or legs? b. A persistent limp? c. Every worn corrective shoes or braces? 35. Neurological Has your child ever had a. Breath holding? b. Convulsions or seizures? c. Dizziness? d. Fainting? e. Frequent headaches?			
Has your child a. Had weakness or paralysis of arms or legs? b. A persistent limp? c. Every worn corrective shoes or braces? 35. Neurological Has your child ever had a. Breath holding? b. Convulsions or seizures? c. Dizziness? d. Fainting? e. Frequent headaches?	·	□ no	☐ yes
a. Had weakness or paralysis of arms or legs? b. A persistent limp? c. Every worn corrective shoes or braces? 35. Neurological Has your child ever had a. Breath holding? b. Convulsions or seizures? c. Dizziness? d. Fainting? e. Frequent headaches?			
b. A persistent limp? c. Every worn corrective shoes or braces? 35. Neurological Has your child ever had a. Breath holding? b. Convulsions or seizures? c. Dizziness? d. Fainting? e. Frequent headaches?			
c. Every worn corrective shoes or braces?			
35. Neurological Has your child ever had a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes			
Has your child ever had a. Breath holding? b. Convulsions or seizures? c. Dizziness? d. Fainting? e. Frequent headaches?		<u> </u>	☐ yes
a. Breath holding? no yes b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes			
b. Convulsions or seizures? no yes c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes			
c. Dizziness? no yes d. Fainting? no yes e. Frequent headaches? no yes			
d. Fainting? no yes e. Frequent headaches? no yes		_	
e. Frequent headaches?			
t. lemper tantrums?	f. Temper tantrums?	□ no	☐ yes

Pediatric Patient Health History Page 5 of 6

36. Is your child				
a. Impulsive?	☐ no ☐ no ☐ no	☐ yes ☐ yes ☐ yes		
b. Lacking in self-control?				
c. Overactive?				
d. Does your child have problems with:				
i. Attending school?		☐ no	☐ yes	
ii. Attention span?		☐ no	☐ yes	
iii. Learning?		☐ no	☐ yes	
iv. Mood?		☐ no	☐ yes	
v. Parents?		☐ no	☐ yes	
vi. Peers?		☐ no	☐ yes	
vii. Siblings?			☐ yes	
viii. Sleep?		☐ no	☐ yes	
ix. Are there concerns about physical, sexual, or emotional abuse?			☐ yes	
(You may call Mental Health Services to set up an evaluation a	t 617.253.2916 for any of the above.)			
37. Has your child begun puberty?	☐ no	☐ yes		
38. Any other concerns you would like to discuss?				
Patient or Guardian Signature	Date			
Provider Name	Provider Name Date Reviewed			

Pediatric Patient Health HistoryV 01-12-24Page 6 of 6