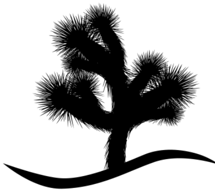

MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

PEDIATRIC HEALTH HISTORY

Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated confidentially.

Today's Date ____________________ SS/HIC/Patient ID # ____________________

Child's Name ____________________ ❒ M ❒ F Date of Birth ____________ Age _______

Mother's Name ____________________ Phone: home (_____) ____________ work (_____) ____________

Father's Name ____________________ Phone: home (_____) ____________ work (_____) ____________

Home Address ____

Email ____________________ Cell Phone #1 (_____) ____________ Cell Phone #1 (_____) ____________

Child's School ____ Grade ____________

Previous Physician ____________________ City/State ____________________ Phone (_____) ____________

ALLERGIES

SUBSTANCE	REACTION
____________	____________________
____________	____________________
____________	____________________

MEDICATIONS

NAME	DOSAGE
____________________	____________
____________________	____________
____________________	____________

Please check the boxes that apply to your child:

❒ Anemia
❒ Asthma
❒ Bronchitis/Bronchiolitis
❒ Bronchopulmonary Dysplasia (BPD)
❒ Chicken Pox
❒ Hepatitis
❒ Immune Deficiency / HIV
❒ Measles (10-day)
❒ Measles, Rubella (3-day)
❒ Mumps
❒ Prematurity
❒ Rheumatic fever
❒ Pneumonia
❒ Sickle Cell Disease
❒ Whooping cough
❒ Other ________________
____

GENERAL SYMPTOMS:
❒ Chills
❒ Depression
❒ Dizziness
❒ Fainting
❒ Forgetfulness
❒ Headache
❒ Loss of sleep
❒ Mood swings
❒ Nervousness
❒ Numbness
❒ Sweating
❒ Tiredness
❒ Weight loss or gain

CARDIOVASCULAR:
❒ Breathing problems
❒ Chest pain
❒ Irregular heart beat

EYES:
❒ Crossed/wandering eyes
❒ Eye irritation
❒ Headaches
❒ Vision problems

HEARING/SPEECH:
❒ Difficulty hearing
❒ Earache
❒ Ear infections
❒ Hoarseness
❒ Speech problems

DENTAL:
❒ Bleeding gums
❒ Grinding teeth
❒ Sensitivity to hot/cold
❒ Thumb-sucking
❒ Last dental checkup was ________________
❒ Brushes teeth, frequency ________________
❒ Floss, frequency ________________

GASTROINTESTINAL:
❒ Appetite poor
❒ Bloody/dark stools
❒ Constipation
❒ Diarrhea
❒ Excessive hunger
❒ Excessive thirst
❒ Nausea
❒ Rectal bleeding
❒ Stomach aches
❒ Vomiting
❒ Worms

GENITO-URINARY:
❒ Bed-wetting
❒ Blood in urine
❒ Diaper rash, persistent
❒ Discharge from vagina/penis
❒ Frequent urination
❒ Painful urination
❒ Unusual urine odor

MUSCLE/JOINT/BONE:
❒ Broken bones or sprains
❒ Coordination problems
❒ Posture problems
❒ Pain, weakness, swelling
❒ Arms ❒ Hips
❒ Back ❒ Legs
❒ Feet ❒ Neck
❒ Hands ❒ Shoulders

NOSE/THROAT/CHEST
❒ Difficulty breathing
❒ Difficulty swallowing
❒ Frequent colds
❒ Hoarseness
❒ Mouth-breathing
❒ Nosebleeds
❒ Persistent cough
❒ Sinus problems
❒ Sore throats
❒ Strep throat
❒ Tonsil infections
❒ Wheezing

SKIN
❒ Bruises easily
❒ Change in moles
❒ Hives
❒ Itching Rash Scars
❒ Sores that won't heal

DIETARY ASSESSMENT:

How often does your child eat the following food items?

	3 times/day	Daily	Weekly	Monthly	Rarely
Beans, peas	❒	❒	❒	❒	❒
Breads, cereals, grains	❒	❒	❒	❒	❒
Candy	❒	❒	❒	❒	❒
Dairy products	❒	❒	❒	❒	❒
Eggs	❒	❒	❒	❒	❒
Fruits	❒	❒	❒	❒	❒
Meats	❒	❒	❒	❒	❒
Poultry, fish	❒	❒	❒	❒	❒
Sodas	❒	❒	❒	❒	❒
Vegetables, green	❒	❒	❒	❒	❒
Vegetables, yellow	❒	❒	❒	❒	❒

What vitamin supplements does your child take? ______________________________ How often? ______________

Is there fluoride in your water? ❒ Yes ❒ No

HOSPITALIZATIONS

REASON	DATE	HOSPITAL / CITY / STATE

SERIOUS INJURIES OR ILLNESSES

EVENT	DATE	OUTCOME

Has your child ever had a blood transfusion: ❒ Yes ❒ No

IMMUNIZATIONS

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
❒	❒	________	Hepatitis B	❒	❒	________	Polio, (3)	❒	❒	________	Measles vaccine
❒	❒	________	DPT (3 shots)	❒	❒	________	Polio booster shot	❒	❒	________	Mumps vaccine
❒	❒	________	DPT booster shot	❒	❒	________	Polio by mouth (3)	❒	❒	________	Rubella vaccine
❒	❒	________	HIB (influenza)	❒	❒	________	PCV7 (Pneumococcal)	❒	❒	________	Chicken Pox vaccine

FAMILY HISTORY

Please provide the following information about your child's immediate family:

	AGE	GENERAL HEALTH
Father	________	____________________________
Mother	________	____________________________

Have any of your children died? ❒ Yes ❒ No

	AGE	GENERAL HEALTH	
Sibling	________	____________________________	❒ M ❒ F
Sibling	________	____________________________	❒ M ❒ F
Sibling	________	____________________________	❒ M ❒ F

List the child's blood-relatives that had the conditions below:

CONDITION	RELATIONSHIP TO CHILD
❒ Alcoholism	
❒ Allergies	
❒ Anemia	
❒ Arthritis	
❒ Asthma/emphysema	
❒ Birth defects	
❒ Bone/joint disorders	
❒ Cancer	
❒ Diabetes	
❒ Epilepsy	
❒ Eye Disorder/blindness	
❒ Hearing loss/ear disorders	
❒ Genetic defects	
❒ Heart disease	
❒ Hemophilia	

CONDITION	RELATIONSHIP TO CHILD
❒ High blood pressure	
❒ HIV / AIDS	
❒ Kidney disease	
❒ Lung disease	
❒ Mental disease/disorder	
❒ Muscle disorders	
❒ Rheumatic fever	
❒ Seizures / convulsions	
❒ Sickle cell anemia	
❒ Skin disease	
❒ Stroke	
❒ Thyroid disease	
❒ Tuberculosis	
❒ Venereal disease	
❒ Other	

PRE-NATAL AND INFANT HEALTH HISTORY

Place of birth ________________________ Obstetrician ________________________ Mother's age at birth _______

Please check all of the following conditions that you experienced during pregnancy:

- ❐ Alcohol use
- ❐ Anemia
- ❐ Diabetes
- ❐ Non-prescription drug use (please list) ______________________
- ❐ Prescription drug use (please list) ______________________
- ❐ Controlled drug use such as narcotics (please list) ______________________
- ❐ Edema (swelling)
- ❐ Exposure to chemical or radiation
- ❐ Fever
- ❐ German measles
- ❐ Hepatitis
- ❐ High blood pressure
- ❐ Protein in urine
- ❐ Tobacco use
- ❐ Urinary tract infection
- ❐ Venereal disease
- ❐ Other illness or infection ______________________

DELIVERY: please indicate all that apply

❐ On time ❐ Premature ❐ Late ❐ Normal ❐ Induced ❐ Prolonged ❐ Breech ❐ C-Section

Please describe: ______________________

INFANT HEALTH:

Birthweight ________________ Length ______________

Discharge weight _____________ Age when discharged ___________

INFANT HEALTH PROBLEMS:

- ❐ Birth defects ______________________
- ❐ Breathing problems ______________________
- ❐ Infection ______________________
- ❐ Jaundice ______________________
- ❐ Transfusion ______________________
- ❐ Other ______________________

FEEDING:

❐ Breast fed ❐ Formula fed

DEVELOPMENTAL: please note age at which your child:

- ❐ Lifted head ________ Week
- ❐ Rolled over ________ Month
- ❐ Cooed/laughed ________ Month
- ❐ Sat up ________ Month
- ❐ Stood up ________ Month
- ❐ Walked ________ Month
- ❐ Finger fed ________ Month
- ❐ Drank from cup ________ Month
- ❐ Spoon fed ________ Month
- ❐ First word ________ Month
- ❐ Toilet trained ________ Month
- ❐ Dressed self ________ Month

EDUCATION AND SOCIAL HISTORY

Please explain any problems or concerns you have about your child in the following areas:

Appearance / weight / height ______________________

____

Behavior ______________________

____

Friends ______________________

____

Grades / learning ability ______________________

____

Sexuality ______________________

____

How many hours per day does your child watch television or play video games? ______________ Gets exercises? _____________

Do you suspect that your child is involved with: ❐ Drugs ❐ Alcohol ❐ Tobacco ❐ None

Have you noticed any of the following warning signs of drug use:

Angry behavior	❐ Yes	❐ No	Depression	❐ Yes	❐ No
Change in appearance	❐ Yes	❐ No	Signs of drugs in the house	❐ Yes	❐ No
Change in attitude	❐ Yes	❐ No	Skipping school	❐ Yes	❐ No
Change in friendship	❐ Yes	❐ No	Withdrawal from family or friends	❐ Yes	❐ No

CHILD SAFETY INVENTORY

Adequate number of working smoke alarms	❒ Yes	❒ No	Safety plugs in unused wall sockets	❒ Yes	❒ No
Does child use care seat / seat belt	❒ Yes	❒ No	Safety gate for stairs	❒ Yes	❒ No
Medicines, cleaning supplies, chemicals out of reach	❒ Yes	❒ No	Assessed for peeling paint, mice/rats in home	❒ Yes	❒ No
Syrup of Ipecac in the home	❒ Yes	❒ No	Child knows how to swim	❒ Yes	❒ No
Know poison control phone number	❒ Yes	❒ No	Guns are locked in storage	❒ Yes	❒ No
Water heater below 120 degrees F	❒ Yes	❒ No	Child wears bicycle helmet	❒ Yes	❒ No

PARENT CONCERNS: Reason for today's visit and any other concerns or questions you have about your child.

____

____

____

____

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

_______________________________________ _______________________

Signature of parent / guardian or personal representative — Date

_______________________________________ _______________________

Print name of above signature — Relationship to patient

FOR INTERNAL USE

PHYSICIAN COMMENTS ____

____

____

UPDATES (to be completed at future appointments)

Has there been any change in child's health since last appointment? ❒ Yes ❒ No

Description: ____

Parent / Guardian signature	Date	Physician signature	Date

Has there been any change in child's health since last appointment? ❒ Yes ❒ No

Description: ____

Parent / Guardian signature	Date	Physician signature	Date

Has there been any change in child's health since last appointment? ❒ Yes ❒ No

Description: ____

Parent / Guardian signature	Date	Physician signature	Date

Has there been any change in child's health since last appointment? ❒ Yes ❒ No

Description: ____

Parent / Guardian signature	Date	Physician signature	Date