Sutter Health

Patient Pediatric Health History Form

For well-child checks, please also use the appropriate well-child questionnaire

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ **AGE:**_____

CHILD'S PREVIOUS DOCTOR/PCP: _____

BIRTH AND PREGNANCY

What city was your child born in?_____Name of hospital: _____

Is this your child by: _____ Birth _____ Adoption _____ Step-child Other: _____

Birth weight: _____ Was your baby premature? **Y / N**

Were there any significant medical problems during your pregnancy? **Y / N**

Were there any significant complications during labor or the baby's newborn period? **Y / N**

If yes, to any of the above questions, please explain: _____

_____

GROWTH AND DEVELOPMENT

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)? **Y / N**

If yes, please explain: _____

Girls only: Age at first period: _____

PAST MEDICAL HISTORY

HAS YOUR CHILD:

Had any serious medical illness?	**Y / N**	Had broken bones/frequent or severe sprains?	**Y / N**
Had a history of asthma or wheezing?	**Y / N**	Had any mental or behavioral problems?	**Y / N**
Ever used an inhaler or nebulizer?	**Y / N**	Had a positive tuberculosis skin test?	**Y / N**
Had surgery?	**Y / N**	Been hospitalized overnight?	**Y / N**

If yes, to any of the above, please explain: _____

_____

IMMUNIZATIONS: ***Please bring your child's immunization records to your appointment***

Have you ever refused vaccines for your child? **Y / N**

If yes, why? _____

MEDICATIONS AND ALLERGIES

Please list current medications, vitamins, and supplements, even those used intermittently: _____

_____

Please list allergies or reactions to medications, vaccines or foods

Allergy	Reaction
_____	_____
_____	_____
_____	_____

FAMILY HISTORY:

Please indicate with a check (./) family members who have had any of the following conditions:

Medical Condition	Admin. use only	Mom 1	Dad 2	Sister 3	Brother 4	Mom's Mom 5	Mom's Dad 6	Dad's Mom 7	Dad's Dad 8	Mom's Sister 12	Mom's Brother 13	Dad's Sister 14	Dad's Brother 15
Alcoholism	33												
Anemia	1												
Asthma	5												
Autism	128												
Autoimmune Disorder	34												
Birth Defect/Congenital Anomaly	36												
Bleeding Problem	7												
Cancer, Breast	8												
Cancer: Please Specify Type _____													
Cancer: Please Specify Type _____													
Depression	14												
Diabetes	81												
Eczema (Atopic Dermatitis)	17												
Food Allergy	39												
Genetic Disorder	19												
Hay Fever (Allergic Rhinitis)	20												
Hearing Disorder	21												
Heart Attack/Coronary Artery Disease	13												
High Cholesterol (Hyperlipidemia)	22												
High Blood Pressure (Hypertension)	23												
Immune Disorder	24												
Inflammatory Bowel Disease (Crohns/UC)	59												
Kidney Disease	25												
Mental Retardation or Learning Disability	40												
Migraine Headaches	71												
Psychiatric/Mental Illness	75												
Scoliosis	76												
Stroke	28												
Substance Abuse	43												
Thyroid Disorders	30												
Tobacco Use	30.5												
Tuberculosis	31												
Death before age 56 or reasons not listed above													
Other:													
Other:													

SOCIAL HISTORY: Please list patient's family and household members:

Name Age Relationship Occupation/Employer Cell Phone Number

_____

_____

_____

_____

_____

Are your child's parents: ___Married ___ Unmarried ___ Separated ___ Divorced (If divorced or separated, when?)

Child-care situation: ___ Parents ___ Others (specify who and hours per day) _____

_____

Concerns about your child: ____ Alcohol use ____ Tobacco ___Sexual activity ____Aggressive behavior

Is violence at home a concern? __ Yes __ No Are there pets in the home? __ Yes __ No

Are there guns in the home? __ Yes __ No Do any family members smoke? __ Yes __ No