WESTWIND
MEDICAL ASSOCIATES
HEALTH & WELLNESS CENTER

Pediatric Health History Form

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Use Form for Ages Birth to 10 Years

Child's Personal Information

Patient Last Name: ______ First Name: ______ Middle Initial: ______

Date Of Birth: *(month/day/year)* ______ Age: ______

Child's Previous Doctor? ______

Current Health Concerns: ______

Current Medications / Vitamins: ______

Current Allergies / Reactions to Medications: ______

Pregnancy & Birth Information

Is This Child Your's By: ☐ Birth ☐ Adoption ☐ Step Child ☐ Other - Specify: ______

Did You Have any Medical Problems During the Pregnancy? If yes, Specify: ______

Delivered By: ☐ Vaginal Birth ☐ Caesarean If Caesarean, Why? ______

Birth Length: ______ Birth Weight: ______ APGAR Score: ______

List Any Medical Issues During Baby's Newborn Period: ______

Nutrition & Feeding Information

Was Your Child Breastfed? ☐ Yes ☐ No If Yes, How Long? ______

Has You Child Had any Unusual Feeding / Dietary Problems? If yes, Specify: ______

Current Milk Intake? ☐ Cow Milk ☐ Non-Fat ☐ 1% ☐ 2% ☐ Whole Milk ☐ Soy Milk ☐ Rice Milk

Average Ounces Per Day (1 Cup = 8 Oz.) ______

Sleep Information

Hours Per Night? [ ] Number of Naps & Length? [ ]

Any Sleep Problems? [ ]

Development Information

At What Age Did Your Child Sit Alone? [ ] Walk Alone? [ ] Say Words? [ ]

Girls Only: Age of First Menstrual Period? [ ] Date of Last Period? [ ]

Immunizations / Infectious Diseases Information

Please bring immunizations records with you to the appointment.

Has Your Child Had? ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis

Major Health Problems / Hospitalizations / Operations / Broken Bones / Severe Pain Information

Please Describe any Medical Problems and Related Dates:

Please List any Hospitalizations / Operations and Related Dates:

Please List any Broken Bones and / or Severe Pain:

Family History Information

Please check all that apply to your family history.

- ☐ Alcoholism / Drug Abuse
- ☐ Heart Disease / Stroke
- ☐ Seizures
- ☐ Psychiatric Disorders
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Bleeding / Clotting Problems
- ☐ Birth Defects
- ☐ Asthma / Hay Fever / Eczema
- ☐ Inherited / Genetic Diseases

Social History Information

Are the Child's Parents: ☐ Married ☐ Separated ☐ Divorced If Divorced, How Long? ______

Parents Occupations? Mother: ______ Father: ______

Child Care? Specifiy who takes care of them and hours per day: ______

Concerns About Your Child: ☐ Alcohol Use ☐ Tobacco ☐ Sexual Activity ☐ Aggressiveness

Is Violence at Home a Concern? ☐ Yes ☐ No Are there Guns in the Home? ☐ Yes ☐ No

School History Information

Does your Child Attend School? ☐ Yes ☐ No Current Grade / Name of School? ______

Any Concerns about School performance? ______

Any Concerns about Relationships with: Teachers? ☐ Yes ☐ No Students? ☐ Yes ☐ No

Sports / Exercise: Type? ______ How Often? ______ How Long? ______

Review of Symptoms Information

Please check all current symptoms that child is experiencing.

General

- ☐ Fever / Chills / Excessive Sweating
- ☐ Unexplained Weightloss

Eyes

- ☐ Squinting / Cross Eyes

Heart / Cardiovascular

- ☐ Tires Easily with Exercise
- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Chest Pain with Exercise

Ears / Nose / Throat

- ☐ Mouth Breathing / Snoring
- ☐ Bad Breath
- ☐ Frequently Runny Nose
- ☐ Problems with Teeth / Gums
- ☐ Unusually Loud Voice / Hard of Hearing

Lungs / Respiratory

- ☐ Cough / Wheezing
- ☐ Chest Pain

Gastrointestinal

- ☐ Nausea / Vomiting / Diarrhea
- ☐ Constipation
- ☐ Blood in Bowel Movement

Genitourinary

- ☐ Bedwetting
- ☐ Pain with Urination
- ☐ Discharge: Penis or Vagina

Musculoskeletal

- ☐ Muscle / Joint Pain

Skin

- ☐ Rashes / Unusual Moles

Allergy

- ☐ Hay Fever / Itchy Eyes

Neurological

- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness
- ☐ Speech Problems

Psychiatric / Emotional

- ☐ Anxiety / Stress
- ☐ Sleep Problems / Nightmares
- ☐ Depression
- ☐ Nail Biting / Thumb Sucking
- ☐ Bad Temper / Holding Breath

Blood / Lymph System

- ☐ Unexplained Lumps
- ☐ Easy Bruising / Bleeding