HAPPY DAYS PEDIATRICS

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HEALTH HISTORY FORM FOR PATIENTS

Today's Date:_____ Form Completed by: _____

Child's Name_____ DOB:_____ Sex: M F

Household: Please list all those living in the child's home

Name	Relationship to Child	Date of Birth	Health Problem

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Birth History: ☐ Don't know birth history

Any prenatal or neonatal complications? **Y N**
Explain_____
Was the baby born at term? **Y N** If not, at how many weeks?_____ Was the delivery ☐vaginal ☐cesearean Birth weight _____
If delivery was cesearean, why?_____
Was a NICU stay required? **Y N** Explain_____
Was initial feeding ☐formula ☐breast milk How long breastfed? _____Did baby go home with mom from hospital? **Y N**
Prenatal exposures: Tobacco ☐Yes ☐No Explain _____
Alcohol ☐ Yes☐ No _____
Prenatal vitamins☐Yes☐No _____
Other medications or drugs _____

General:
Does your child have any serious illnesses or medical conditions? ☐Yes ☐No Explain _____
Is your child on any medications or supplements?☐Yes ☐No Explain _____
Has your child had any surgery? ☐Yes☐No Explain _____
Has your child ever been hospitalized?☐Yes☐No Explain _____
Is your child allergic to any medications? ☐Yes ☐No Explain _____

Past History: *Does your child have, or has your child ever had,*

Chickenpox	☐Yes ☐ No ☐Don't Know	When _____
Frequent ear infections, ear or hearing problems	☐Yes ☐ No ☐Don't Know	Explain _____
Nasal allergies	☐Yes ☐ No ☐Don't Know	Explain _____
Problems with eyes or vision	☐Yes ☐ No ☐Don't Know	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐Yes ☐ No ☐Don't Know	Explain _____
Any heart problem or heart murmur	☐Yes ☐ No ☐Don't Know	Explain _____
Anemia or bleeding problem	☐Yes ☐ No ☐Don't Know	Explain _____
Organ transplant	☐Yes ☐ No ☐Don't Know	Explain _____
Malignancy/bone marrow transplant	☐Yes ☐ No ☐Don't Know	Explain _____
Acid reflux	☐Yes ☐ No ☐Don't Know	Explain _____
Constipation requiring doctor visits	☐Yes ☐ No ☐Don't Know	Explain _____
Recurrent urinary tract infections and problems	☐Yes ☐ No ☐Don't Know	Explain _____
Metabolic/Genetic disorders	☐Yes ☐ No ☐Don't Know	Explain _____
Cancer	☐Yes ☐ No ☐Don't Know	Explain _____
Kidney disease or urologic malformations	☐Yes ☐ No ☐Don't Know	Explain _____
Bed-wetting (after 5 years old)	☐Yes ☐ No ☐Don't Know	Explain _____
Sleep problems, snoring	☐Yes ☐ No ☐Don't Know	Explain _____
Chronic/recurrent skin problems(ex. Acne, eczema)	☐Yes ☐ No ☐Don't Know	Explain _____
Frequent headaches	☐Yes ☐ No ☐Don't Know	Explain _____
Convulsions or other neurologic problems	☐Yes ☐ No ☐Don't Know	Explain _____
Diabetes	☐Yes ☐ No ☐Don't Know	Explain _____
Thyroid or other endocrine problems	☐Yes ☐ No ☐Don't Know	Explain _____
High blood pressure	☐Yes ☐ No ☐Don't Know	Explain _____
History of serious injuries/fractures/concussions	☐Yes ☐ No ☐Don't Know	Explain _____
ADHD/anxiety/mood problems/depression	☐Yes ☐ No ☐Don't Know	Explain _____
Developmental delay	☐Yes ☐ No ☐Don't Know	Explain _____
Dental decay	☐Yes ☐ No ☐Don't Know	Explain _____
For girls, problems with her periods	☐Yes ☐ No ☐Don't Know	Explain _____
Has had her first period ☐Yes☐No	Age of first period_____	

Biological Family History: *Have any family members had the following?*

Childhood hearing loss	☐ Yes ☐No ☐ Don't Know	Who _____
Nasal allergies	☐ Yes ☐No ☐ Don't Know	Who _____
Asthma	☐ Yes ☐No ☐ Don't Know	Who _____
Congenital Heart Disease	☐ Yes ☐No ☐ Don't Know	Who _____
Childhood/adolescent onset seizures	☐ Yes ☐No ☐ Don't Know	Who _____
SIDS/Sudden death of a child or adolescent	☐ Yes ☐No ☐ Don't Know	Who _____
Childhood or adolescent cancer	☐ Yes ☐No ☐ Don't Know	Who _____
Tuberculosis	☐ Yes ☐No ☐ Don't Know	Who _____
Heart disease (before 55 years old)	☐ Yes ☐No ☐ Don't Know	Who _____
High cholesterol/takes cholesterol medications	☐ Yes ☐No ☐ Don't Know	Who _____
Blood problems (anemia, bleeding disorder)	☐ Yes ☐No ☐ Don't Know	Who _____
Liver disease	☐ Yes ☐No ☐ Don't Know	Who _____
Kidney disease	☐ Yes ☐No ☐ Don't Know	Who _____
Diabetes (before 55 years old)	☐ Yes ☐No ☐ Don't Know	Who _____
Bedwetting (after 10 years old)	☐ Yes ☐No ☐ Don't Know	Who _____
Mental illness/depression	☐ Yes ☐No ☐ Don't Know	Who _____
Developmental disability	☐ Yes ☐No ☐ Don't Know	Who _____