

Sandy Springs Pediatrics and Adolescent Medicine

PEDIATRIC HEALTH HISTORY

Please complete this form as completely and accurately as you can. If you are unsure of how to answer an item, just circle it and we will be glad to discuss it with you.

Date _____ Previous Pediatrician _____

Child's Name _____ Male Female Date of Birth _____

Mother's Name _____ Father's Name _____

Home address _____

Allergies

Medications

MEDICAL HISTORY

Please check if your child has any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Measles (10-day)
<input type="checkbox"/> Measles, Rubella
<input type="checkbox"/> Mumps
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Whooping cough
<input type="checkbox"/> other _____ | Cardiovascular
<input type="checkbox"/> Breathing problem
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Irregular heart beat

Eyes
<input type="checkbox"/> crossed or wandering eyes
<input type="checkbox"/> Eye irritation
<input type="checkbox"/> Headaches
<input type="checkbox"/> Vision problems

Hearing/Speech
<input type="checkbox"/> Difficulty hearing
<input type="checkbox"/> Earache
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Speech problems _____

Dental
<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Grinding teeth
<input type="checkbox"/> Sensitivity to hot/cold
<input type="checkbox"/> Thumb-sucking
<input type="checkbox"/> Last dental check-up
Date _____
<input type="checkbox"/> Brush, how often? _____
<input type="checkbox"/> Floss, how often? _____

Gastrointestinal
<input type="checkbox"/> Appetite poor | <input type="checkbox"/> Fecal Soiling
<input type="checkbox"/> Bloody or dark Stools
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Excessive hunger
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Nausea
<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Reflux
<input type="checkbox"/> Stomachaches
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Worms

Genito-urinary
<input type="checkbox"/> Bed-wetting/pants
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Diaper rash, persistent
<input type="checkbox"/> Discharge from vagina or penis
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Painful urination
<input type="checkbox"/> Unusual urine odor

Muscle/Joint/Bone
<input type="checkbox"/> Broken bones or sprains
<input type="checkbox"/> Coordination problems
<input type="checkbox"/> Posture problems
<input type="checkbox"/> Pain/weakness/swelling | <input type="checkbox"/> Arms
<input type="checkbox"/> Back
<input type="checkbox"/> Feet
<input type="checkbox"/> Hands

<input type="checkbox"/> Hips
<input type="checkbox"/> Legs
<input type="checkbox"/> Neck
<input type="checkbox"/> Shoulders

Nose/Throat/Chest
<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Mouth-breathing
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Snoring
<input type="checkbox"/> Sore throats
<input type="checkbox"/> Strep throat
<input type="checkbox"/> Tonsil infections
<input type="checkbox"/> Wheezing/RAD/Bronch

Skin
<input type="checkbox"/> Acne
<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Change in moles
<input type="checkbox"/> Hives
<input type="checkbox"/> Itching/Rash
<input type="checkbox"/> Scars
<input type="checkbox"/> Sores that won't heal |
|--|---|---|---|

General

-
- Chills
-
-
- Depression
-
-
- Dizziness
-
-
- Fainting
-
-
- Forgetfulness
-
-
- Headache
-
-
- Loss of sleep
-
-
- Mood swings
-
-
- Nervousness
-
-
- Numbness
-
-
- Sweating
-
-
- Tiredness
-
-
- Weight loss/gain
-
-
- Chronic/Recurrent fever

Dietary Assessment

How often does your child eat the following:

	3 times daily	Daily	Weekly	Monthly
Beans, peas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breads, cereals, grain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poultry, fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sodas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables, green	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables, yellow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What vitamin supplements does your child take? _____ How often? _____

Is there fluoride in your water? Yes No

Hospitalizations

Injuries

Reason	Date	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Serious Injuries/Illnesses	Date	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Age	General Health	Age	General Health
Father _____	_____	Sibling _____	<input type="checkbox"/> M <input type="checkbox"/> F
Mother _____	_____	Sibling _____	<input type="checkbox"/> M <input type="checkbox"/> F
Have any of your children died? <input type="checkbox"/> Y <input type="checkbox"/> N	_____	Sibling _____	<input type="checkbox"/> M <input type="checkbox"/> F
		Sibling _____	<input type="checkbox"/> M <input type="checkbox"/> F

Please check conditions that any of your child's blood relatives (including parents & siblings) have had and indicate the relationship to the child:

Condition	Relationship
<input type="checkbox"/> Alcoholism _____	_____
<input type="checkbox"/> Allergies _____	_____
<input type="checkbox"/> Anemia _____	_____
<input type="checkbox"/> Arthritis _____	_____
<input type="checkbox"/> Asthma/emphysema _____	_____
<input type="checkbox"/> Birth defects _____	_____
<input type="checkbox"/> Bone/joint disorders _____	_____
<input type="checkbox"/> Cancer _____	_____
<input type="checkbox"/> Diabetes _____	_____
<input type="checkbox"/> Epilepsy _____	_____
<input type="checkbox"/> Eye/ear disorders/hearing loss/Blindness _____	_____
<input type="checkbox"/> Genetic defects _____	_____
<input type="checkbox"/> Heart disease _____	_____
<input type="checkbox"/> Hemophilia _____	_____
<input type="checkbox"/> High blood pressure _____	_____
<input type="checkbox"/> Unknown Child Adopted	

Condition	Relationship
<input type="checkbox"/> HIV/AIDS _____	_____
<input type="checkbox"/> Kidney disease _____	_____
<input type="checkbox"/> Lung disease _____	_____
<input type="checkbox"/> Mental disease/disorder _____	_____
<input type="checkbox"/> Mental retardation _____	_____
<input type="checkbox"/> Muscle disorders _____	_____
<input type="checkbox"/> Rheumatic fever _____	_____
<input type="checkbox"/> Seizures/convulsions _____	_____
<input type="checkbox"/> Sickle cell anemia _____	_____
<input type="checkbox"/> Skin disease _____	_____
<input type="checkbox"/> Stroke _____	_____
<input type="checkbox"/> Thyroid disease _____	_____
<input type="checkbox"/> Tuberculosis _____	_____
<input type="checkbox"/> Venereal disease _____	_____
<input type="checkbox"/> Other _____	_____

Pre-Natal and Infant Health History

Place of birth _____ Obstetrician _____

During the pregnancy did mother have any of the following? Check all that apply

- Alcohol Use Anemia Diabetes Fever High Blood Pressure
 Tobacco Use Edema Sexually Transmitted Disease Other Illnesses _____
 Drugs used, non-prescription _____
 Drugs used, prescription _____

Birth weight _____ Length _____ APGARS _____ Discharge weight _____ Age when discharged _____

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

Infant Health Problems - Please check and describe.

- Birth defects _____ Breathing problems _____
 Infection _____ Jaundice _____
 Transfusion _____ Other _____

Feeding Breast fed Formula fed

Developmental - Please note age at which your child:

Lifted head _____ Wk. Rolled over _____ Mo. Cooed/Laughed _____ Mo.
Sat up _____ Mo. Stood up _____ Mo. Walked _____ Mo.
Walked _____ Mo. Finger fed _____ Mo. Drank from cup _____ Mo.
Spoon fed _____ Mo. First word _____ Mo. Toilet trained _____ Mo.
Dressed Self _____ Mo.

Education and Social History

Please explain any problems you have about your child in any of 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? _____ Get exercise? _____

Extra curricular activities? _____

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

