FLYNN FAMILY MEDICINE

*Caring for your whole family overseas*

# 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 | Mom | Dad | Sister | Brother | Mom's Mom | Mom's Dad | Dad's Mom | Dad's Dad | Mom's Sister | Mom's Brother | Dad's Sister | Dad's Brother |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | | | | | | |
| Anemia | | | | | | | | | | | | |
| Asthma | | | | | | | | | | | | |
| Autism | | | | | | | | | | | | |
| Autoimmune Disorder | | | | | | | | | | | | |
| Birth Defect/Congenital Anomaly | | | | | | | | | | | | |
| Bleeding Problem | | | | | | | | | | | | |
| Cancer, Breast | | | | | | | | | | | | |
| Cancer: Please Specify Type _____ | | | | | | | | | | | | |
| Cancer: Please Specify Type _____ | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | |
| Eczema (Atopic Dermatitis) | | | | | | | | | | | | |
| Food Allergy | | | | | | | | | | | | |
| Gentic Disorder | | | | | | | | | | | | |
| Hay Fever (Allergic Rhinitis) | | | | | | | | | | | | |
| Hearing Disorder | | | | | | | | | | | | |
| Heart Attack/Coronary Artery Disease | | | | | | | | | | | | |
| High Cholesterol (Hyperlipidemia) | | | | | | | | | | | | |
| High Blood Pressure (Hypertension) | | | | | | | | | | | | |
| Immune Disorder | | | | | | | | | | | | |
| Inflammatory Bowel Disease (Crohns/UC) | | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | | |
| Mental Retardation or Learning Disability | | | | | | | | | | | | |
| Migraine Headaches | | | | | | | | | | | | |
| Psychiatric/Mental Illness | | | | | | | | | | | | |
| Scoliosis | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | |
| Substance Abuse | | | | | | | | | | | | |
| Thyroid Disorders | | | | | | | | | | | | |
| Tobacco Use | | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | | |
| 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