South Austin Medical Clinic Pediatric Health History Form – NEW Patient

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

CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER:_____

PRESENT HEALTH CONCERNS:_____

_____

MEDICINES/VITAMINS:_____

_____

ALLERGIES TO MEDICINES OR VACCINATIONS:_____

PREGNANCY & BIRTH
Is this child yours by: birth adoption stepchild other
Please indicate any medical problems during pregnancy none specify:_____
Number of weeks Gestation: Preterm____ # of wks Full term (38-40 wks) Post term_____# of wks
Delivery by: vaginal birth caesarian If caesarian, why?_____
Birth weight:_____ Birth length:_____
Please indicate any medical problems during the baby's newborn period none

_____
Other problems:_____

NUTRITION & FEEDING
Was your child breastfed? No Yes If so, how long?_____
Has your child had any unusual feeding/dietary problems? No Yes If yes, specify:_____
Milk intake now: Type cow milk (non-fat 1%fat 2%fat whole milk) soy milk rice milk
Average ounces per day (Note: 8 ounces are in 1 cup)_____

DEVELOPMENT Girls only: Age at first menstrual period_____

DENTAL HISTORY: Has child been seen by a dentist? No Yes If so, date of last visit_____

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) No Yes
Do any household members smoke? No Yes
SCHOOL/ DAYCARE Not in school In school Where?_____ Grade?_____
Daycare?_____ Remedial/Special Ed
Sports / exercise:_____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates:

_____

_____

_____

Hospitalizations/Operations (with dates):_____

_____

Broken bones or severe sprains_____
FAMILY HISTORY: Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

SOCIAL HISTORY: Birthplace_____

Who lives at home?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are the child's parents □married □unmarried □separated □divorced □ domestic partner

Parents' occupations: Parent _____ Parent _____

REVIEW OF ORGAN SYSTEMS:

Constitutional / Endocrine
□Fevers/chills/excessive sweating
□Unexplained weight loss / gain

Eyes
□Squinting/"crossed" eyes/ asymmetric gaze

Ears / Nose / Throat
□Unusually loud voice/hard of hearing
□Mouth breathing/snoring
□Bad breath
□Frequent runny nose
□Problems with teeth/gums

Respiratory
□Cough/wheeze
□Clumsiness

Muscular / Skeletal
□Muscle/joint pain

Gastrointestinal
□Nausea/vomiting/diarrhea
□Constipation
□Blood in bowel movement

Cardiovascular
□Tires easily with exertion
□Shortness of breath
□Fainting

Genitourinary
□Bedwetting
□Pain with urination
□Discharge: penis or vagina

Neurological
□Headaches
□Weakness
□Unexplained lumps

Allergy
□ Sneezing/itchy eyes/runny nose

Skin
□Rashes
□Unusual moles

Psychiatric / Emotional
□Speech Problems
□Anxiety/stress
□Problems with sleep/ nightmares
□Depression
□Nail biting/thumb sucking
□Bad temper/breath holding/ jealousy

Blood / Lymph
□Easy bruising/bleeding

-PLEASE COMPLETE BOTH SIDES OF THIS FORM