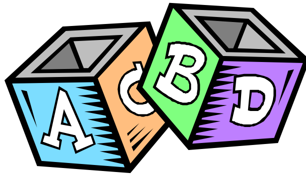
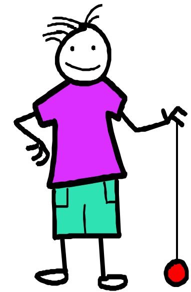


Overlake Family Medicine
Pediatric Health History

THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORD.



Date ______________________________ ID # __________________________ Male Female
Child's Name ______________________________ Date of Birth _______________ Age _________
Mother's Name ______________________________ Phone (home) _______________ Phone (work) ______________
Father's Name ______________________________ Phone (home) _______________ Phone (work) ______________
Home Address ____
Child's School ______________________________ Grade _______
Previous Physician __________________________ City/State ___________________ Phone ______________________
Reason for Visit ____

ALLERGIES

Substance	Reaction

MEDICATIONS

Name	Dose

MEDICAL HISTORY

Please check if the child has had any of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Birth Defects
- ☐ Breathing problems
- ☐ Bronchitis /
- ☐ Bronchiolitis
- ☐ Bronchopulmonary dysplasia (BPD)
- ☐ Chicken pox
- ☐ Hepatitis
- ☐ Immune deficiency or HIV
- ☐ Measles
- ☐ Mumps
- ☐ Prematurity
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Whooping Cough
- ☐ Other

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mood swings
- ☐ Sweating
- ☐ Nervousness
- ☐ Numbness
- ☐ Tiredness
- ☐ Weight loss or gain

CARDIOVASCULAR
- ☐ Breathing problems
- ☐ Chest pain
- ☐ Irregular heartbeat

EYES
- ☐ Crossed or wandering
- ☐ Eye irritation
- ☐ Headaches
- ☐ Vision problems

HEARING/SPEECH
- ☐ Difficulty hearing
- ☐ Earache
- ☐ Ear infections
- ☐ Hoarseness
- ☐ Speech problems

DENTAL
- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Thumb sucking
- ☐ Last dental checkup Date: __________

GASTROINTESTINAL
- ☐ Appetite problem
- ☐ Bloody or dark stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomachaches
- ☐ Vomiting
- ☐ Worms

GENITO-URINARY
- ☐ Bed wetting
- ☐ Blood in urine
- ☐ Diaper rash, persistent
- ☐ Discharge from vagina or penis
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Unusual urine odor

MUSCLE/JOINT/BONE
- ☐ Broken bones or sprains
- ☐ Coordination problems
- ☐ Posture problems
- ☐ Pain, weakness, swelling in:
  - ☐ Arms ☐ Hips
  - ☐ Back ☐ Legs
  - ☐ Feet ☐ Neck
  - ☐ Hands ☐ Shoulders

NOSE/THROAT/CHEST
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Mouth breathing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sore throats
- ☐ Tonsil infections
- ☐ Wheezing

SKIN
- ☐ Bruises easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

OTHER
- ☐ Behavior problems
- ☐ Blood transfusions
- ☐ Drug use
- ☐ Learning difficulty
- ☐ Obesity
- ☐ Sexual activity
- ☐ Smoking

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HOSPITALIZATIONS

Date	Reason
________________	________________________
________________	________________________
________________	________________________
________________	________________________

INJURIES

Date	Type
________________	________________________
________________	________________________
________________	________________________
________________	________________________

PRENATAL HISTORY

Delivery was (check all that apply):

- ☐ Early
- ☐ Late
- ☐ Premature
- ☐ On Time
- ☐ Normal
- ☐ Induced
- ☐ Prolonged
- ☐ C-Section

Birth Weight: ____________ Length: ________________

Discharge Weight: ____________ Days in Hospital: _________

Place of Birth: ____________________________________

Delivering Physician: __________________________________

Mother's Age at Delivery: ________

Describe any relevant details of birth:

____

Feeding

☐ Breast ☐ Bottle ☐ Both

FAMILY HISTORY

	Age	General Health
Father	_____	________________
Mother	_____	________________
Sibling	_____	________________
Sibling	_____	________________
Sibling	_____	________________
Other	_____	________________

Number in Household: ______

Are there pets in the home? List: ______________________

Is there cigarette/pipe smoke in the home? _____________

Is your water fluoridated? ______________________________

Who lives at home? _____________________________________

What are their occupations? ____________________________

How old is your home? __________________________________

Are there any significant changes or stressors at home currently?____

Check if anyone in the family had/has any of the following:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Asthma
- ☐ Arthritis
- ☐ Birth defects
- ☐ Blindness
- ☐ Bone/joint disorders
- ☐ Cancer
- ☐ Developmental delay
- ☐ Emphysema
- ☐ Genetic defects
- ☐ Hearing or vision problems
- ☐ Heart disease
- ☐ Hemophilia
- ☐ HIV/AIDS
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Mental illness
- ☐ Muscle disorders
- ☐ Seizures/convulsions
- ☐ Sickle cell anemia
- ☐ Skin disease
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis

This is to certify that I have answered the questions on this form to the best of my knowledge. I understand that to provide incorrect information about my child's health and symptoms could place my child's health at risk.

______________________	______________________	____________
Name of Parent/Guardian	Signature of Parent/Guardian	Date
	Signature of Reviewing Physician	Date

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