

# TLC PEDIATRIC & ADOLESCENT MEDICINE, P.A.

## Pediatric Health History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Child's previous doctor/primary care provider: \_\_\_\_\_

Approximate date of child's last well-child checkup: \_\_\_\_\_

Who Lives at Home (please list every household member):

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

Are your child's parents:  Married  Unmarried  Separated  Divorced

If divorced or separated, when? \_\_\_\_\_

What is the child's time sharing status? \_\_\_\_\_

Who primarily takes care of the child?: Parents Others \_\_\_\_\_

### Birth History

Is the child yours by:  Birth  Adoption  Stepchild Birth weight: \_\_\_\_\_

Was the baby born at term?  Y  N (details) \_\_\_\_\_

Please indicate any medical problems during pregnancy \_\_\_\_\_

During pregnancy, did mother use drugs, alcohol, smoke or take medications?  Y  N

If yes, details: \_\_\_\_\_

Did your baby have any problems right after birth?  Y  N If yes details: \_\_\_\_\_

### Nutrition and Feeding

Has your child had any unusual feeding/dietary problems or food allergies? \_\_\_\_\_

Milk intake (children under 2y.o.):  Cow's milk (Nonfat  1%  2%  Whole)  Soy  Rice

### Development

At what age did your child: Sit alone \_\_\_\_\_ Walk alone \_\_\_\_\_

Say words \_\_\_\_\_

Toilet Train: Daytime \_\_\_\_\_ Nighttime \_\_\_\_\_

Any concerns about your child's physical development? \_\_\_\_\_

Any concerns about your child's mental/emotional/behavioral development?  Y  N If yes details: \_\_\_\_\_

### School History

Does your child attend school or preschool  Y  N Where: \_\_\_\_\_ Current grade \_\_\_\_\_

Has he/she had any problems in school (failed or repeated a grade, special classes, etc)?  Y  N If yes, details: \_\_\_\_\_

Any concerns about school performance or behavior?  Y  N If yes, details: \_\_\_\_\_

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**Patient Name:** \_\_\_\_\_

## Dental History

Does your child see a dentist regularly?  Y  N

## Immunization History/Infectious Diseases

To the best of your knowledge is your child up to date with his/her vaccinations?  Y  N

Has your child ever had chickenpox?  Y  N If yes, what year? \_\_\_\_\_

## Exposure/Habits

Any concerns about lead exposure? ( live in old home or old plumbing/peeling paint) \_\_\_\_\_

Do any household members smoke?  Y  N If yes, who? \_\_\_\_\_

## Past Medical History

Does your child have any serious illnesses/medical conditions?  Y  N If yes, details: \_\_\_\_\_

Has your child had serious injuries or accidents?  Y  N \_\_\_\_\_

Has your child had any surgery?  Y  N \_\_\_\_\_

Has your child ever been hospitalized?  Y  N \_\_\_\_\_

Is your child allergic to any medicines or drugs?  Y  N \_\_\_\_\_

What medications is your child currently taking?  Y  N \_\_\_\_\_

For girls, age at first menstrual period \_\_\_\_\_

Does your child have, or ever had:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Frequent ear infections          | <input type="checkbox"/> Hearing problems                   | <input type="checkbox"/> Nasal allergies   |
| <input type="checkbox"/> Vision problems                  | <input type="checkbox"/> Asthma, bronchiolitis or pneumonia |  |
| <input type="checkbox"/> Heart problem or murmur          | <input type="checkbox"/> Anemia/bleeding problem            | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Constipation                     | <input type="checkbox"/> Urinary tract infection            |  |
| <input type="checkbox"/> Skin problem (eczema, acne, etc) | <input type="checkbox"/> Frequent headaches                 | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Thyroid problem                    | <input type="checkbox"/> Weight problem    |
| <input type="checkbox"/> Use of alcohol or drugs          |   |  |

## Family History

Please indicate any family members (parent, sibling, grandparent, aunt or uncle ) with any of the following:

Deafness \_\_\_\_\_

Asthma \_\_\_\_\_

Heart disease before 50 y.o. \_\_\_\_\_

High blood pressure before 50 y.o. \_\_\_\_\_

High cholesterol before 50 y.o. \_\_\_\_\_

Anemia \_\_\_\_\_

Bleeding disorder \_\_\_\_\_

Liver disease \_\_\_\_\_

Kidney disease \_\_\_\_\_

Diabetes before 50 y.o. \_\_\_\_\_

Bedwetting after 10 y.o. \_\_\_\_\_

Seizures \_\_\_\_\_

Alcoholism/Drug Abuse \_\_\_\_\_

Mental Illness (include mental retardation) \_\_\_\_\_

Cancer, specify type \_\_\_\_\_

Genetic disorders \_\_\_\_\_

Other \_\_\_\_\_