WFMA

Waynesboro Family Medical Associates, LLP

PEDIATRIC HEALTH HISTORY

(Use from birth to 10 years)

Today's Date:______________

Child's Name:___________________________________ Date of Birth:________ Age:____

PREGNANCY AND BIRTH Where was your child born? ____________________________

___ Vaginal ___ C- Section

Is this child yours by: ___ Birth ___Adoption ___Stepchild ___Other:______________________

Medical problems during pregnancy: ___ None ___Yes(specify)__________________________

During pregnancy did you use: ___Tobacco ___Illegal drugs ___Alcohol __Medications

(List):____

Birth Weight_____ Birth Length________APGAR scores 1 min._______/5 min.______________

Problems during newborn period: ___None ___Premature, how early? ____ Other____________

NUTRITION & FEEDING

Breastfed? ___No ___Yes, how long?____________ Bottle? ___Yes ___No

Has your child had any problems with eating or foods?(List)______________________________

Intake now: ___Breast Milk ___Formula ___Cow's milk (1%, 2%, whole milk) _ Soy _Rice_Juice

___Other (Water, Soda, Tea) Average ounces per day (8 oz = 1 cup)___________

___Baby food ___Table food ___Meats ___Fruits __Vegetables __Whole grains

___Sweets ___ Junk food

SLEEP Any concerns/problems with sleep? (list)___________________________________

Hours per night:___________ Naps __No __Yes, number and length:_____________________

Where does your child sleep? __Bassinette __Crib __Own bed __Parents room __Other______

DEVELOPMENT At what age did your child: Smile____ Sit alone____ Walk alone___

Say words___ Toilet train___Ride a tricycle___ Read words___First menstrual period___

DENTAL HISTORY Has your child been seen by a dentist? __No __Yes, how often?________

Date of last dental visit:________ What type of water does your child drink? __ CIty __Well

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IMMUNIZATIONS/INFECTIOUS DISEASES Did you bring your child's immunization record to their appointment? __No __Yes ___Will bring to next appointment __ Records with another Dr

Has your child had: __ Chicken Pox __Measles __Mumps __Rubella __Tuberculosis(TB)

__ Hepatitis B __ Meningitis __Pneumonia __Influenze (flu)

EXPOSURE/HABITS Does the patient, or do any household members:

Use tobacco? __No __Yes Use illegal drugs? __No __Yes Drink alcohol? __No __Yes

Concerns about lead exposure? __No __Yes __Old home __Old plumbing __Peeling paint

Signature of person completing this form:____

Reviewed by provider:____

PEDIATRIC HEALTH HISTORY

Child's Name:_______________________________________ Today's Date:__________________

PAST MEDICAL HISTORY Previous doctor: __None __Yes(name)______________________

Allergies/reactions to medicines or vaccines: _______________________________________

Current Medications (including vitamins, herbs, supplements, birth control pills)

Name Dose How many times per day When started

____

____

____

Major Medical Problems: __None __Yes (list): _____________________________________

Hospitalizations/Operations: __ None __Yes (list): __________________________________

Broken bones/Severe Injuries: __None __Yes (list):___________________________________

FAMILY HISTORY Please note family members (mother, father, sister, brother, aunt, uncle, grandparents)

Alcoholism ___ Heart attack ___ High Cholesterol ___ Stroke ___ Cancer___ Diabetes___

High blood pressure ___ Depression/suicide ____ Sudden/Early death ___ Other____________

SOCIAL HISTORY List all household members below:

Name Age Relationship

____

____

____

Are the child's parents : __Married __Unmarried __Separated __Divorced __Other___________

If separated/divorced, when? _______________________

Mothers occupation: ________________________ Employer:______________________________

Father's occupation: ________________________ Employer:______________________________

Child care situation: __Parent(s) __Daycare __Other(specify):___________________________

Concerns about your child? __Alcohol use __Tobacco use __Drug use __Sexual activity

__ Aggressive behavior __ Violence at home

SAFETY Check all that apply:

Are there guns in the home? __ No __ Yes Uses infant/booster seat/seat belt? __No __Yes

Smoke detectors in home? __ No __ Yes Wears helmet for bike/scooter/ATV use? _No _Yes

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SCHOOL HISTORY Does your child attend school? __Yes __No - _Public _Private _Home

Current grade: _____ Name of school: ____

Any problems with school grades, teachers, or student relationships? __ No __Yes___________

Involved in activities/sports/exercise? __No __Yes(list)__________________________________

Signature of person completing this form:____

Reviewed by Provider:____

PEDIATRIC HEALTH HISTORY

Childs Name:____ Today's Date:_________

REVIEW OF SYSTEMS Please check any current problems your child has on the list below:

General
__fevers/chills/excessive sweating
__unexplained weight loss/gain

Eyes
__squinting/cross eyes

Ears/Nose/Throat
__unusually loud voice/hearing issue
__mouth breathing/snoring
__bad breath
__frequently runny nose
__ problems with teeth/gums

Heart/Cardiovascular
__tires easily with exercise
__shortness of breath
__fainting

Lungs/Respiratory
__cough/wheeze
__chest pain

Gastrointestinal
__nausea/vomiting/diarrhea
__ constipation
__blood in bowel movement

Genitourinary
__ bedwetting
__ pain with urination
__discharge:penis or vagina

Musculoskeletal
__muscle/joint pain

Skin
__rashes
__unusual moles

Allergy
__hay fever/itchy eyes

Neurological
__headaches
__weaknesss
__ clumsiness
__speech problems

Psychiatric/Emotion
__anxiety/stress
__problems with sleep
__depression
__temper/jealousy
__ nail biting
__thumb sucking

Blood/Lymph
__unexplained lumps
__easy bruising

Signature of person completing this form:_______________________________________

Reviewed by
Provider:____0