

Angel Kids Pediatrics

Pediatric and Adolescent Medicine Health History

Patient's Name: _____ Sex: M or F Date of Birth: _____

Today's Date: _____

Has your child ever had an allergic reaction to medicine, food, or an insect bite or sting? **YES** **NO**

IDENTIFICATION	BIRTH HISTORY
Name of person filling out this form and relationship to the child: _____ _____	Did the child's mother have any illnesses or problems during her pregnancy labor, or delivery? Yes No Don't Know
Is this child adopted? Yes or No	Was the baby premature?
FAMILY HISTORY Child's Mother's Name _____	Was the baby delivered by cesarean section?
Parents are: Married Divorced Remarried Separated Single	Did the baby have any problems breathing at birth?
Who does the child live with? Mother Father Other or Both	Did the baby have a seizure (convulsion)?
Others who live in the home: (name/age/relation) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Did the baby have any other problems at birth or in the first few weeks of life?
Who cares for the child during the day or after school? _____	Was the baby's discharge delayed for any reason? Baby's birth weight: _____ lbs _____ ozs
	HAS YOUR CHILD EVER: Been in the hospital overnight? Had surgery/operation? Been seen in an emergency room? Seen a medical specialist?

FAMILY HISTORY (siblings, parents, grandparents, aunt, uncle)	YES	NO	MEDICAL HISTORY (for your child)	YES	NO
Birth defect/deformity			Chicken Pox		
Mental Illness/retardation			Rheumatic fever		
Convulsions/seizures			Tuberculosis or positive TB test		
Family or inherited diseases			Hepatitis		
Serious or fatal childhood illness			Eye or vision problems		
Vision or Hearing problems			Ear or hearing problem		
Asthma, hay fever, eczema, allergies			Dental problems		
Tuberculosis			Speech problems		
Diabetes			Recurrent sore throat/tonsillitis		
Thyroid disease			Bronchitis/pneumonia		
Heart attacks under age 50			Wheezing or asthma		
Heart disease at birth			Allergic problems		
High cholesterol			Frequent runny nose		
High blood pressure			Recurrent nosebleeds		
Peptic ulcer			Recurrent skin rash or eczema		
Kidney problems			Stomach or bowel problems		
Blood or bleeding disorder			Hernia		
Sickle cell anemia			Bedwetting/soiling		
Cancer			Urine/Kidney problems/infections		
Immune disorder			Anemia or blood problems		
Accidental poisoning			Heart condition		
Smoke regularly			High blood pressure		
Alcohol abuse			Fainting spell		
Drug abuse			Joint pain or swelling		
Stroke			Bone problems/fractures		
Depression/Anxiety			Convulsions/seizures		
Learning Disorder			High blood pressure		
ADHD			ADD/learning disabilities		
Other Health Problems			Other health problems		

BEHAVIOR ISSUES	YES	NO	GENERAL HISTORY	YES	NO
Frequent Headaches			Does your child:		
Discipline problems			Have all needed immunizations		
Trouble getting along with others			Take medication regularly		
Restless, fidgety, or destructive			Take fluoride in vitamins or water		
Nervousness or unusually fearful			See dentist regularly		
Persistently sad or depressed			Receive sex education at home		
Use of tobacco, drugs, or alcohol			FOR FEMALES		
Sexual activity or victim of sex abuse			Menstrual problems		
Other behavior problems			Vaginal discharge		
Sleep problems			Periods began at age _____		