Tots 'N' Teens Pediatrics, P.C.
Pediatric Health History

Child's Name: ______________________________ Today's Date: ______________________
SSN#: __________________________________Date of Birth: _____________________
Age: _____________ Sex: ________________ Race: _________________

Previous Physician:____
Present Health Concerns:____
____
Medications/Vitamins:____
____
Herbs/HomeRemedies:____
Allergies/Reactions to Medications or Vaccines or Foods:________________________________
____
____

Pregnancy and Birth

Is this child yours by: birth adoption stepchild other: ___________________
Delivery by: vaginal C-section (why? ____)
Birth Weight: _______________ Length of Pregnancy: _____________________
Problems during pregnancy: diabetes high blood pressure alcohol use tobacco use
swelling protein in urine urinary tract infection breech anemia
urinary tract infection venereal disease (gonorrhea, chlamydia, syphilis)
Other infection or illness:____
Medications taken during pregnancy:____
Any medical problems in the newborn period?____
____

Nutrition and Feeding

Was your child breastfed? No Yes If yes, how long? ___________________________
Was your child formula fed? No Yes If yes, which brand?__________________________
Has your child had any unusual feeding/dietary problems? No Yes If yes, specify: _____
____
Milk intake: cow milk (skim 1% fat 2% fat whole soy milk) Amount per day___________
Juice: No Yes If yes, amount per day? _______________________
Soda/Tea: No Yes If yes, amount per day? _______________________

Sleep

Hours per night: _____________ Naps (number and length): _____________
Any sleep problems?____

Development

At what age did your child: sit alone ______ walk alone ______ potty train _____
first words _____
Girls: Age of first menstrual cycle _______

Dental History

Has your child been seen by a dentist? No Yes Date of last visit? _______
Has child had: filling cap/crown braces

Past Medical History

Has your child had: asthma seasonal allergies diabetes pneumonia
bronchiolitis urinary tract infection chicken pox anemia ADHD
seizures eczema recurrent ear infections behavior problems

Describe any major medical problems and their dates:______________________

____

____

____

Hospitalizations (with dates):______________________

____

Surgeries:______________________

Specialists Seen:______________________

Broken Bones and Other Injuries (with dates):______________________

____

Social History

Who lives at home? Do any of the household members smoke? Yes No

Name	Age	Relationship	Highest Education Level
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

Are the child's parents: married unmarried separated divorced

Parents Occupations: Mother ______________ Father ______________

Childcare: parents daycare babysitter other: ______________

Concerns about your child: alcohol use tobacco sexual activity
drugs aggressive behavior

Is violence at home a concern? Yes No Are there guns at home? Yes No

Hours per day of: TV - _____ Computer - _____ Video Games - _____

How does your child get exercise? ______________________

____

School History

School: ______________ Grade: _____ Grades: ______________

Learning concerns: ______________________

Any concerns about relationships with teachers or students: ______________________

____

The information that I have provided is, to the best of my knowledge, true.

Signature ______________________

Relationship to patient ______________________

Physician Signature and Date : ______________________