

Ponderosa Pediatrics - Where Kids Come First

HEALTH HISTORY FORM BIRTH TO 4 YEARS

NAME _____ AGE _____ DOB ____/____/____
 Previous Last name (if different than above): _____

SEX: MALE/ FEMALE (circle one)

SOCIAL HISTORY:

Mother's Name: _____ DOB: ____/____/____ Occupation: _____
 Father's Name: _____ DOB: ____/____/____ Occupation: _____

Please List all people in your household other than the patient:

NAME	DATE OF BIRTH	RELATION TO PATIENT

Does child have another household in which s/he sometimes lives? YES NO If Yes, with whom/where:

Does child attend day care, pre-school or baby sitter regularly? YES NO _____

Have there been major changes or stresses in child's life recently? YES NO If Yes, please explain:

BIRTH HISTORY:

Place of Birth _____ Birth Weight _____ Birth Length _____
 If Yes, please explain:

During Pregnancy did Mother use alcohol or other drugs? YES NO _____

Was there any problems during pregnancy or delivery? YES NO _____

Was baby born prematurely or require special care at birth? YES NO _____

Did baby stay longer in the hospital Than Mother? YES NO _____

PAST MEDICAL HISTORY:

Does child have any allergies? YES NO If Yes, please list:

Has child ever been hospitalized? YES NO If Yes, provide date and reason:

Has child had any surgery, broken bones or fractures? YES NO _____

Turn this form over & complete the back.

Ponderosa Pediatrics - Where Kids Come First

MEDICAL HISTORY CONTINUED:

Has child been diagnosed with any medical or behavioral problem? YES NO

If Yes, please explain:

Does child currently take any medications (Rx or OTC) or treatments? YES NO

FAMILY HISTORY:

Has child's Mother, Father, brother(s), sister(s), Grandparents, Aunts, or Uncles had the following conditions?

If Yes, please give relation/who?

Allergies/Asthma YES NO

Birth defect YES NO

Bleeding disorder YES NO

Cancer YES NO

Diabetes YES NO

Drug or Alcohol use/abuse YES NO

Headaches/Migraines YES NO

Heart attacks/disease YES NO

High Blood Pressure YES NO

High Cholesterol YES NO

Kidney Disease YES NO

Lung Disease YES NO

Mental Illness/ Depression YES NO

Obesity/ Overweight YES NO

Sickle cell Anemia YES NO

Seizures YES NO

Thyroid disease YES NO

Tuberculosis YES NO

Have any of the child's brothers or sisters died? YES NO

Any family member <50 years died suddenly of causes other than accident of violence? YES NO

DEVELOPMENT:

Do you have any concerns about the following?

If Yes, please explain:

Development YES NO

Behavior YES NO

Sleeping habits YES NO

Bathroom/Toilet habits YES NO

Discipline YES NO

Other YES NO

SAFETY:

Does your child use a car seat, booster seat or seat belt in automobiles? YES NO

Does your child wear a helmet when riding bike, scooter, skateboard, or roller blades? YES NO

Is there a gun/firearm in the home? YES NO

Is there verbal or physical fighting occurring in your house? YES NO

Completed by (Parent/Guardian's signature) _____ Date _____

Reviewed by (Provider's signature) _____ Date _____