Ponderosa Pediatrics – Where Kids Come First

HEALTH HISTORY FORM
5-18 YEARS

NAME______________________________AGE__________ DOB____/____/_____
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 or baby sitter regularly? YES ☐ NO☐

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

PAST MEDICAL HISTORY:

Was child born prematurely or require special care at or after birth? YES ☐ NO☐ If Yes, provide date and reason:
____
____
____

Has child ever been hospitalized? YES ☐ NO☐
____
____
____

Has child had any surgery, broken bones or stitches? YES ☐ NO☐
____
____

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

Has child been diagnosed with a medical, behavioral, or development problem? YES ☐ NO☐
____
____
____
____

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

Does child wear eyeglasses, contact lenses, braces or a retainer? YES ☐ NO☐
____
____
____

Does child have any vision, hearing or speech problems? YES ☐ NO☐
____

Turn this form over & complete the back.

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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?

Condition			
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□	______________________________ ______________________________

SCHOOL/DEVELOPMENT HISTORY:

Name of School the child attends ________________________ Grade level _____________

Grade point average (Please circle) A B C D F

If Yes, please explain:

Do you or the child's teachers have concerns about child's development? YES □ NO□ ______________________________
____
____

Does child have any learning disability or special education needs/ (IEP)? YES □ NO□ ______________________________
____
____

BEHAVIOR

Do you have any concerns about the following? If Yes, please explain:

Behavior	YES □	NO□	___________________________
Sleeping habits	YES □	NO□	___________________________
Bathroom/Toilet habits	YES □	NO□	___________________________
Discipline	YES □	NO□	___________________________
Other	YES □	NO□	___________________________

SAFETY:

Does child use a booster seat or seat belt in automobiles?	YES □	NO□
Does child wear a helmet when riding bike, scooter, skate board 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__________