Pacific Crest Pediatric Health History – Page 1 of 2

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: _____

PRESENT/PAST HEALTH CONCERNS: _____

MEDICINES/VITAMINS: _____ **HERBS/HOME REMEDIES:** _____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: ☐Birth ☐Adoption ☐Stepchild ☐Other _____

Please indicate any medical problems during pregnancy: ☐ None ☐Preeclampsia ☐Smoking ☐Drugs ☐alcohol ☐high blood pressure ☐IUGR ☐ gestational diabetes ☐other _____

Delivery by: ☐Vaginal birth ☐ Caesarean (If Caesarean, why?) _____

Birth weight: _____

Please indicate any medical problems during the baby's newborn period: ☐None ☐ premature, how early? _____

Other problems: _____

NUTRITION AND FEEDING

Current Feeding Method: ☐Breast ☐ Formula/Type _____

Has your child had any unusual feeding/dietary problems ☐ No ☐ Yes If yes, specify: _____

Milk intake now (>1 year old) Type ☐Cow's Milk (☐Nonfat ☐1% ☐2% ☐Whole milk) ☐Soy milk ☐Rice milk

Average ounces per day (Note: 8 ounces = 1 cup) _____

SLEEP

Any sleep problems? ☐No ☐Yes _____

DEVELOPMENT

Any concerns about development? ☐No ☐ Yes _____

Girls only: Age at first menstrual period _____

HOSPITALIZATIONS/OPERATIONS (with dates) _____

DENTAL HISTORY: Has child been seen by dentist? ☐No ☐Yes If so, how often? _____ Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES: *Please bring your child's immunization records to your appointment.*

Has your child had: ☐Chickenpox ☐Tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? ☐No ☐Yes (see below for common risk factors)

Live in or visit a home or childcare facility built before 1960?

Live in or regularly visit a home built before 1980 that is being repainted or remodeled?

Were recently adopted or have recently immigrated from another country?

May have been given traditional remedies such as azarcon, greta, paylooah, or kohl?

Do any household members smoke? ☐No ☐Yes

TV-hours per day? _____ Computer hours per day? _____ Video games-hours day? _____

SOCIAL HISTORY:

Who lives at home? Please list below:

Name	Age	Relationship

Are your child's parents: ☐Married ☐Unmarried ☐Separated ☐Divorced If divorced or separated, when? _____

Mother's Occupation: _____ Father's Occupation: _____

Child care situation: ☐ Parents ☐Others (specify who and hours per day) _____

Concerns about your child: ☐Alcohol Use ☐Tobacco ☐ Sexual Activity ☐Aggressive Behavior

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

SCHOOL HISTORY:

Did/does your child attend school or preschool? ☐No ☐Yes Current grade: _____

Any concerns about school performance? _____

If more than 4 years old: does your child have a best friend? ☐No ☐Yes

Sports/Exercise: Type: _____ How often? _____ How long (minutes)? _____

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FAMILY HISTORY: Please indicate with a (√) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Problem	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, Breast	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, Melanoma	☐	☐	☐	☐	☐	☐	☐	☐
Congenital Anomaly/birth defect	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, Colon	☐	☐	☐	☐	☐	☐	☐	☐
Hay Fever/Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack/Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes: on insulin shots	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes: not on insulin	☐	☐	☐	☐	☐	☐	☐	☐
Hearing Disorder	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Immune Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐	☐	☐
Mental Retardation or Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐
Death before age 56 for reason not listed above	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

REVIEW OF SYMPTOMS: Please *check (√) any current* problems *your child has on the list below:*

Constitutional
- ☐ Fevers/Sweats/Weakness
- ☐ Unexplained Weight Loss/Gain

Eyes
- ☐ Squinting/"crossed" eyes

ENT/mouth
- ☐ Unusually loud voice/ hard of hearing
- ☐ Mouth Breathing/snoring
- ☐ Bad Breath
- ☐ Frequent Runny nose
- ☐ Problem with teeth/gums
- ☐ Hay fever/Allergies

Cardiovascular
- ☐ Tires easily with exertion
- ☐ Shortness of Breath
- ☐ Fainting

Respiratory
- ☐ Cough/Wheeze

Gastrointestinal
- ☐ Blood in Bowel Movement
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Constipation

Genitourinary
- ☐ Discharge: penis or vagina
- ☐ Bedwetting
- ☐ Pain with urination

Musculoskeletal
- ☐ Muscle/joint pain

Skin
- ☐ Rash/new or change in mole

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness

Psychiatric
- ☐ Anxiety/stress
- ☐ Sleep Problem/nightmares
- ☐ Depression
- ☐ Speech Problems
- ☐ Nail biting/thumb sucking
- ☐ Bad temper/breath holding jealousy

Blood/Lymphatic
- ☐ Unexplained Lumps
- ☐ Easy bruising/bleeding