

# DRS. SAUER AND LEIBENSPERGER FAMILY PRACTICE

## Pediatric Health History Form

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

PERSON COMPLETING FORM: \_\_\_\_\_ RELATIONSHIP TO CHILD: \_\_\_\_\_

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: \_\_\_\_\_

PRESENT HEALTH CONCERNS: \_\_\_\_\_

MEDICINES/VITAMINS: \_\_\_\_\_

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: \_\_\_\_\_

### PREGNANCY & BIRTH

Is this child yours by:  birth  adoption  stepchild  other \_\_\_\_\_

Please indicate any medical problems during pregnancy  none  specify: \_\_\_\_\_

Delivery by:  vaginal birth  caesarian If caesarian, why? \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR score 1 min: \_\_\_\_\_ 5 min. \_\_\_\_\_

Please indicate any medical problems during the baby's newborn period  none If premature, how early? \_\_\_\_\_

Other problems: \_\_\_\_\_

### NURTITION & FEEDING

Was your child breastfed?  No  Yes If so, how long? \_\_\_\_\_

Has your child had any unusual feeding/dietary problems?  No  Yes If yes, specify: \_\_\_\_\_

Milk intake now: Type  cow milk ( non-fat  1%  2%  whole milk)  soy milk  rice milk

Average ounces per day (Note: 8 ounces are in 1 cup) \_\_\_\_\_

### SLEEP

Hours per night \_\_\_\_\_ Naps (number & length) \_\_\_\_\_

Any sleep problems? \_\_\_\_\_

### DEVELOPMENT

At what age did your child: sit alone \_\_\_\_\_ walk alone \_\_\_\_\_ say words \_\_\_\_\_ toilet train (daytime) \_\_\_\_\_

Girls only: Age at first menstrual period \_\_\_\_\_

**DENTAL HISTORY:** Has child been seen by a 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  measles  mumps  rubella  meningitis  tuberculosis (TB)

**EXPOSURES/HABITS:** Any concerns about lead exposure? (old home/plumbing/peeling paint)  No  Yes

Do any household members smoke?  No  Yes

TV – hours per day \_\_\_\_\_ Computer – hours per day \_\_\_\_\_ Video Games – hours per day \_\_\_\_\_

**PAST MEDICAL HISTORY:** Please describe any major medical problems and their dates

\_\_\_\_\_

\_\_\_\_\_

Hospitalizations/Operations (with dates): \_\_\_\_\_

\_\_\_\_\_

Broke bones or severe sprains \_\_\_\_\_

**- PLEASE COMPLETE BOTH PAGES OF THIS FORM-**

**FAMILY HISTORY:** Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

**SOCIAL HISTORY:**

Birthplace \_\_\_\_\_ Current (or upcoming) grade: \_\_\_\_\_

Who lives at home?

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Highest Education Level</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the child's parents  married  unmarried  separated  divorced If divorced, when? \_\_\_\_\_

Parents' occupations: Mother \_\_\_\_\_ Father \_\_\_\_\_

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 preschool?  No  Yes Current grade \_\_\_\_\_ Name of School \_\_\_\_\_

Any concerns about school performance? \_\_\_\_\_

Any concerns about relationships with: Teachers  No  Yes \_\_\_\_\_

Students  No  Yes \_\_\_\_\_

If over 4 years old, does your child have a best friend?  No  Yes

Sports / exercise: Type \_\_\_\_\_ How often? \_\_\_\_\_ How long (minutes) \_\_\_\_\_

**REVIEW OF ORGAN SYSTEMS:** If child has more than one symptom on a line, circle the relevant one(s).

Constitutional/Endocrine

Fevers/chills/excessive sweating

Unexplained weight loss/ gain

Eyes

Squinting/"crossed" eyes/  
asymmetric gaze

Ears/Nose/Throat

Unusually loud voice/hard of  
hearing

Mouth breathing/snoring

Bad breath

Frequent runny nose

Problems with teeth/gums

Respiratory

Cough/wheeze

Gastrointestinal

Nausea/vomiting/diarrhea

Constipation

Blood in bowel movement

Cardiovascular

Tires easily with exertion

Shortness of breath

Fainting

Genitourinary

Bedwetting

Pain with urination

Discharge: penis or vagina

Neurological

Headaches

Weakness

Clumsiness

Muscular/Skeletal

Muscle/joint pain

Allergy

Hayfever/itchy eyes

Skin

Rashes

Unusual moles

Psychiatric/Emotional

Speech Problems

Anxiety/stress

Problems with sleep/  
nightmares

Depression

Nail biting/thumb-sucking

Bad temper breath-  
holding / jealousy

Blood/Lymph

Unexplained lumps

Easy bruising/bleeding