MONTEREY PENINSULA
pediatric
MEDICAL GROUP
2 Upper Ragsdale Drive
Suite B-210
Monterey, CA 93940

Pediatric Health History Form

Name:_______________________ Birthday:__________Today's Date_____________

Your relationship to child:______________

Child's previous doctor/primary care provider: ______________________

Present health concerns:

____
____
____
____

PREGNANCY & BIRTH

Where was your child born?______________

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

Please indicate any medical problems during pregnancy

☐ None ☐ Specify:

Delivery by ☐ Vaginal birth ☐ Caesarean

If Caesarean, 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: __________________________

NUTRITION & 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: ☐ Cow's milk (☐ Nonfat ☐ 1% fat ☐ 2% fat ☐ Whole) ☐ Soy milk ☐ Rice milk

Average ounces per day (8 ozs. = 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

Please bring your child's immunization records to your appointment.

ILLNESS AND INJURIES

Has your child had any of the following diseases:

☐ Chickenpox ☐ Measles ☐ Mumps
☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)
☐ Asthma ☐ Allergies ☐ Poison ingestion
☐ Broken Bones(s) ☐ Knocked unconscious
☐ Urinary tract infection ☐ Ear infections
☐ Feeding problems ☐Vision problems
☐ Heart murmur ☐Pneumonia

EXPOSURE/HABITS

Any concerns about lead exposure? Old home/ plumbing/peeling paint) ☐ No ☐ Yes

Do any household members smoke? ☐ No ☐ Yes

TV – hours per day ____________________

Computers – hours per day ______________

Video games – hours per day _____________

HOSPITAL, SURGERY, OTHER MAJOR ILLNESS OR INJURY

Date	Describe why hospitalized, nature of surgery, what illness

DRUGS CURRENTLY TAKEN ☐ NONE

(Once/month or more)

Drug	How Often	What for?

ALLERGIC REACTION

Drug/Food/Vaccine	Date of Reaction	What Happened?

FAMILY HISTORY

Please indicate any deaths of your immediate family members:______________________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FAMILY HISTORY (Continued)

Please circle any family history of the following conditions and indicate family members affected (parent, sibling, grandparent, aunt or uncle)

Alcoholism/drug abuse_________________________
High cholesterol/High blood pressure_____________
Cancer, specify type___________________________
Heart disease or stroke before age 60____________
Bleeding or clotting disorder_____________________
Genetic disorders/Birth defects___________________
Asthma/hay fever/eczema______________________
Diabetes____________________________________
Kidney Disease_______________________________
Seizures / Thyroid disease______________________
Depression/ Suicide ___________________________
Psychiatric disorders__________________________
Other: ______________________________________

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship
_______________	_____	________________
_______________	_____	________________
_______________	_____	________________
_______________	_____	________________
_______________	_____	________________
_______________	_____	________________
_______________	_____	________________

Are your child's parents ◻ Married ◻ Unmarried ◻ Separated ◻ Divorced
If divorced or separated, when? ________________
Mother's Occupation_________________________
Mother's Employer ___________________________
Father's Occupation__________________________
Father's Employer____________________________
Child care situation ◻ Parents ◻ Others (specify who and how often)___________________________
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______________________
Name of school ______________________________
Any concerns about school performance?
____
Any concerns about relationship with:
Teachers ◻ No ◻ Yes
Peers ◻ No ◻ Yes
If more than 4 years old: does your child have a best friend? ◻ No ◻ Yes

SPORTS AND EXERCISE

Types_______________________________________
____
How often?_______________
How long (minutes daily)?_____________________

REVIEW OF SYMPTOMS: Please check or circle any current problems your child has on the list below:

General
- ☐ 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

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

Respiratory
- ☐ Cough/wheeze
- ☐ Chest pain

Gastrointestinal
- ☐ Nausea/vomiting /diarrhea
- ☐ Constipation
- ☐ Blood in bowel movement

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

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Skin
- ☐ Rashes
- ☐ Unusual moles

`*Allergy*
- ☐ Hay fever/itchy eyes
- ☐ Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness

Psychiatric/Emotional
- ☐ Speech problems
- ☐ Anxiety/stress
- ☐ Sleep issues
- ☐ Depression
- ☐ Nail biting/thumb sucking
- ☐ Bad temper /breath holding/ jealousy

Blood/Lymph
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

PLEASE COMPLETE BOTH SIDES OF THIS FORM