

PEDIATRIC Health History Form



Name: _____

DOB: _____

Sex: M F

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us? _____

Present Status:

Are you in good health at the present time to the best of your knowledge? Yes No

Explain a "no" answer: _____

Are you under a doctor's care at the present time? Yes No

If yes, for what? _____

Prescription Drugs: List all

Drug:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Over-the-Counter medications, vitamins, supplements: List all

Product:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use Only:

Date: _____

Chart # _____

Goal Weight: _____

Start Weight _____

Chest: _____

Waist: _____

Hip: _____

Waist/Hip Ratio: _____

Reviewed by: _____

Any allergies to any medications? Foods? Yes No

Please list: _____

History of High Blood Pressure? Yes No

History of Diabetes? Yes No At what age: _____

History of Heart Attack or Chest Pain or other heart condition? Yes No

History of Swelling Feet? Yes No

History of Frequent Headaches? Yes No

Migraines? Yes No Medications for Headaches: _____

History of Constipation (difficulty in bowel movements)? Yes No

History of Glaucoma? Yes No

History of Sleep Apnea? Yes No

If "yes", do you wear your CPAP? Yes No

Gynecologic History:

Pregnancies

Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual

Onset: _____

Duration: _____

Are they regular: Yes No

Pain associated: Yes No

Last menstrual period: _____

Birth Control Method: _____

Any Surgery: Yes No

Specify: (List all)

Date

_____	_____
_____	_____
_____	_____
_____	_____

Family History: (please note if anyone had a sudden death under 45 years old)

Age	Health	Disease	Cause of Death	Overweight?
Father: _____				
Mother: _____				
Brothers: _____				
Sisters: _____				

Review of Systems: (Check all that apply)

General: Fatigue Night Sweats Unexplained weight change

Eyes: Visual trouble Trouble with eye pressure Eye redness/discharge

Ears: Difficulty hearing Ringing in ears

Nose: Chronic discharge/drainage

Throat: Sore throat Difficulty swallowing

Lungs: Wheezing Shortness of breath Snoring Asthma Waking gasping for breath

Chest/Heart: Chest pain Palpitations Irregular heartbeat History of Rheumatic fever

Hematology: Easy bruising Trouble with blood clotting Nose bleeds Miscarriage(s)

GI: Abdominal pain Nausea Vomiting Heartburn

Change in bowel habits or stool constipation/diarrhea

Bladder: Kidney stones Urinary frequency/urgency Blood in urine Prostate issues

Circulation: Varicose veins Leg swelling

Musculoskeletal: Back pain Joint pain

Neurology: Headaches Dizziness Passing out Migraines Stroke

Allergy: Hives Rash Itchiness

Sleep: Trouble falling asleep Trouble staying asleep Snoring Never feel rested

Psychiatric: Depression Anxiety Bipolar

Past Medical History: (check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Valve Disorder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gallbladder Disorder | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Clot |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Atrial Fibrillation/Dysrhythmia | | |

Other: _____

Nutrition Evaluation

Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

In what time frame would you like to be at your desired weight?

Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____

What is the main reason for your decision to lose weight? _____

When did you begin gaining excess weight? (Give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when? _____

Previous diets/medication you have done: _____

Give dates and results of your weight loss: _____

Is your mother, father, grandparents overweight? Yes No Are your siblings overweight? Yes No

By how much is he or she overweight? _____

How often do you eat out? _____

What restaurants do you frequent? _____

How often do you eat "fast foods?" _____

Who plans meals? _____ Cooks? _____ Shops? _____

Do you use a shopping list? Yes No

What time of day and on what day do you usually shop for groceries?

Food allergies: _____

Food dislikes: _____

Food(s) you crave: _____

Any specific time of the day or month do you crave food? _____

Do you drink coffee or tea? Yes No How much daily? _____

Do you drink cola drinks? Yes No How much daily? _____

Do you drink alcohol? Yes No

What? _____ How much daily? _____ Weekly? _____

Do you use a sugar substitute? Yes No Butter? Yes No Margarine? Yes No

Do you awaken hungry during the night? Yes No What do you do? _____

What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____

When you are under a stressful situation at work or family related, do you tend to eat more? Yes No

Explain: _____

Do you think you are currently undergoing a stressful situation or an emotional upset? Yes No

Explain: _____

Smoking Habits: (answer only one)

You have never smoked You quit smoking years ago You smoke __ cigarettes per day

Typical Breakfast: _____

Time Eaten: _____

Where: _____

With whom: _____

Typical Lunch: _____

Time Eaten: _____

Where: _____

With whom: _____

Typical Dinner: _____

Time Eaten: _____

Where: _____

With whom: _____

Describe your usual energy level:

Previous exercise routine/schedule: _____

What is your current exercise routine? _____

Any exercise limitations? _____

Activity Level: (answer only one)

Inactive: no regular physical activity with a sit-down job.

Light activity: no organized physical activity during leisure time.

Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.

Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session 4 times per

week.

Behavior style: (answer only one)

- You are always calm and easygoing.
- You are usually calm and easygoing.
- You are sometimes calm with frequent impatience.
- You are seldom calm and persistently driving for advancement.
- You are never calm and have overwhelming ambition.
- You are hard-driving and can never relax.

Mental Health

Have you ever been diagnosed or treated for Anxiety or Depression? Yes No

Have you ever been treated or diagnosed with an Eating Disorder? (Anorexia, Bulimia, Binge Eating) Yes No

Night Eating Syndrome) Yes No

Do you panic when stressed? Yes No

Do you cry frequently? Yes No

Have you ever attempted suicide? Yes No

Have you ever seen a counselor? Yes No

Please describe your general health goals and improvements you wish to make: _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form. By signing this form, I am indicating all health history is accurate and correct.

Child Name _____

Signed: _____

Date: _____