MISSION EAST DALLAS
FAMILY HEALTH CLINIC

PEDIATRIC HEALTH HISTORY

(Ages 0-18 years)

Name_____Date of Birth_____

Age: _____ Date: _____

(Month/Day/Year)

I. ANSWER THE FOLLOWING QUESTIONS (Check Yes or No and fill in the blanks):

Yes	No	Questions
		Where was your child born? _____ If not US, where? _____ (Hospital)
		Were there any problems during your pregnancy? If yes, explain: _____
		Was your delivery Vaginal or C-Section? Were there any problems? If yes, explain: _____
		Was your child born premature? If yes, were there any problems? _____
		What was your child's birth weight? _____ Birth Length? _____
		Did your child have a primary care physician previously? _____ Date of last exam: _____
		Does your child have a dentist? _____ Date of last exam: _____
		Is your child currently taking any medications? List: _____
		Does your child have any allergies to medications? _____
		Does your child have any allergies to food? List: _____
		Has your child ever been hospitalized? Why? _____ Where? _____
		Has your child had any serious injuries? When? _____ Where? _____
		Has your child had any surgeries? When? _____ Where? _____

II. HAS YOUR CHILD HAD OR CURRENTLY HAVE PROBLEMS IN THESE AREAS? (Check Yes or No):

Yes	No	Questions	Yes	No	Questions
		Head			Kidney/Bladder

		Eyes			Lungs/asthma/bronchitis/pneumonia
		Ears/nose/throat			Bones/muscles/joints
		Heart/murmur/high blood pressure			Anemia
		Stomach/constipation			Skin/rashes
		Wear glasses or contacts?			Wear dental bridges/plates/braces?

III. HAS YOUR CHILD HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING? (Check Yes or No):

Yes	No	Questions	Yes	No	Questions
		Hepatitis			Diabetes
		Chickenpox			Had a seizure
		Asthma, Hives, Eczema, or Hay Fever			Anemia
		Dizzy or passed out during or after exercise?			Been unconscious/had a concussion?

IV. HAS YOUR CHILD HAD OR CURRENTLY HAVE HAD ANY OF THE FOLLOWING? (Check Yes or No):

Yes	No	N/A	Questions	Yes	No	N/A	Questions
			Problems walking				Breastfed as an infant? How long?
			Problems toilet training				Problems with diet
			Problems with colic				Use/d any special diets
			Problems in school				Attended a special school or classes
			Problems with sleeping				Nightmares
			Problems with bedwetting				Discipline or behavior problems
			Problems with nail biting				Ever seen a Psychologist
			Problems with weight/height				Speech Therapist or Speech Teacher

V. FAMILY HISTORY (Check Yes or No and fill the blanks—use other side if needed):

Yes	No	Questions	Yes	No	Questions
		Any smokers in the home?			Brothers/sisters. How many: _____
		Father health problems: _____			Brothers/sisters health problems: _____
		Mother health problems: _____			

VI. ANY FAMILY HISTORY OF? (Check Yes or No): List family members if Yes:

Yes	No	Questions	Yes	No	Questions
		Diabetes: who? _____			Seizures: who? _____
		Allergies: who? _____			Heart Disease: who? _____
		TB: who? _____			Cancer: who? _____
		HIV: who? _____			Hepatitis: who? _____

		Mental Health problems: who? _____			

VII. FOR FEMALES ONLY (Check Yes or No) AGES 10 AND ABOVE

Yes	No	Questions	Yes	No	Questions
At what age did your child start her first period? _____					Is your child taking birth control? If yes, type of birth control: _____

Yes	No	Questions
		Are you or your children exposed to domestic abuse/violence?
		Does your child have any other diseases or medical conditions NOT listed on this form? If so, please explain: _____
		If you moved to this area in the past year, where did your child live before coming to this area? _____ When did you move here? _____
		Do you have any religious, cultural or other factors that might influence your child's care? If so, please list: _____
		Any special comments about your child? _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change in my child's health or medications.

Parent or Guardian's signature _____ Date _____