

Pediatric Health History

(Confidential)



Name | Today's Date / / /

Age | Birth date / / /

Reason for today's visit?

SYMPTOMS Check (X) symptoms your child currently has or has had in the past year.

General

- [ ] Chills
- [ ] Depression
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Forgetfulness
- [ ] Headache
- [ ] Loss of sleep
- [ ] Loss of weight
- [ ] Nervousness
- [ ] Numbness
- [ ] Sweats
- [ ] Unsteady Gait

Muscle/Joint/Bone

Pain, weakness, numbness in:

- [ ] Arms
- [ ] Back
- [ ] Feet
- [ ] Hands
- [ ] Hips
- [ ] Legs
- [ ] Neck
- [ ] Shoulders

Urinary

- [ ] Blood in Urine
- [ ] Frequent Urination
- [ ] Lack of Bladder control
- [ ] Painful Urination

Gastrointestinal

- [ ] Appetite poor
- [ ] Bloating
- [ ] Bowel changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive hunger
- [ ] Excessive thirst
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Stomach Pain
- [ ] Vomiting
- [ ] Vomiting blood

Cardiovascular

- [ ] Chest pain
- [ ] High blood pressure
- [ ] Irregular heart beat
- [ ] Low blood pressure
- [ ] Poor circulation
- [ ] Rapid heart beat
- [ ] Swelling of ankles

Eye, Ear, Nose, Throat

- [ ] Bleeding gums
- [ ] Blurred vision
- [ ] Crossed eyes
- [ ] Difficulty Swallowing
- [ ] Double vision
- [ ] Earache
- [ ] Ear discharge
- [ ] Hay fever
- [ ] Hoarseness
- [ ] Itchy/watery eyes
- [ ] Red goopy eyes
- [ ] Loss of hearing
- [ ] Nose bleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Runny Nose
- [ ] Sinus problems
- [ ] Vision-Flashes
- [ ] Vision-Halos

Skin

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scars
- [ ] Sore that won't heal

Pulmonary

- [ ] Cough
- [ ] Wheezing
- [ ] Shortness of breath
- [ ] Difficulty breathing

Young men only

- [ ] Breast lumps
- [ ] Lump in testicles
- [ ] Penis discharge
- [ ] Sore on penis
- [ ] Other

Young women only

- [ ] Abnormal pap smear
- [ ] Bleeding between periods
- [ ] Breast lumps
- [ ] Extreme menstrual pain
- [ ] Nipple Discharge
- [ ] Vaginal discharge
- [ ] Other _____

Date of last menstral period _____

Date of last pap smear _____

Have you had a mammogram _____

Are you pregnant _____

Number of children

FAMILY HISTORY Check (X) If any of the following conditions are present in your parents, grandparents, aunts, uncles or siblings.

- [ ] Cancer
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Seizure Disorder
- [ ] Migraines
- [ ] Asthma
- [ ] Allergies or Hay Fever
- [ ] Heart Attack
- [ ] Stroke
- [ ] Other _____

Medications Please indicate any medication you the patient is currently taking.	**Allergies** To medication/substances

Concerns you would like to address with us today