

**Pediatric Associates of Williamsburg
Pediatric Patient Health History**

Child's Name _____ Nickname: _____ Date of Birth _____

Child's Previous Doctor/Primary Care Provider: _____

Child lives with (circle): Mother Father Stepmother Stepfather Siblings Other: _____

PREGNANCY & BIRTH

The child's biological status: Birth Adoption Stepchild other: _____

Delivered by: vaginal birth Caesarian If caesarian, why? _____

Any related complications: None Pregnancy Labor Delivery Nursery

PATIENT'S HISTORY:

Place of Birth: _____ Are the child's parents: married unmarried divorced separated

Do any of the child's caretakers smoke? Yes No If so, whom? _____

Do you and your children always use a seatbelt/carseat/booster seat? Yes No

TV (hours per day) _____ Computer/Video Games (hours per day) _____

Daycare, Preschool, School? Yes No School or learning problems? _____

Any serious injury? Yes No _____ Been hospitalized? Yes No _____

Any repeated illness? Yes No _____ Any surgery? Yes No _____

Reaction to any medication? Yes No _____ Taking any medications? Yes No List: _____

Please check if your child has had any of the following:

Allergy: Medications _____ Food Latex Hayfever or itch eyes

Blood/Lymph: Unexplained lumps Easily bruises or bleeds Anemia High blood pressure

Cardiovascular: Easily tires Shortness in breath Fainting Heart disease or murmur

Constitutional/ Endocrine: Fevers/chills Excessive sweating Weight loss or gain

Eyes: Disease/injury Squinting Crossing Eyes Gazing

Ears/Nose/Throat: Congestion Difficulty hearing Mouth Breathing/snoring Bad breath Frequent runny nose

Problems with teeth/gums (sores) Frequent ear infections Ear tubes

Gastrointestinal: Nausea/diarrhea Constipation Blood in bowel movement Abnormal thirst/appetite

Genitourinary: Bedwetting Frequent/painful urination Discharge: penis or vagina

Muscular/Skeletal: Muscle/joint pain Spine curvature

Neurological: Headaches Weakness Clumsiness

Psychiatric: Speech problems Anxiety/Stress Trouble sleeping Depression Behavior ADHD/ADD

Respiratory: Prolonged or frequent coughing Wheezing Asthma

Skin: Burns Birthmarks Disease Rashes Unusual moles

Infections: chickenpox measles mumps rubella meningitis tuberculosis

Other: _____

Check here if your child has none of the above:

SIBLINGS		
Name	Date of Birth	Gender

FAMILY HISTORY

Please check if any family history of the conditions listed below and list person next to the condition. In addition to immediate family, include: Uncles, Aunts, and Grandparents associated with the condition.

Asthma	Y / N _____	Alcoholism/Drug Abuse	Y / N _____	Allergies	Y / N _____
Arthritis	Y / N _____	Birth Defects	Y / N _____	Blood Problems	Y / N _____
Cancer	Y / N _____	Diabetes	Y / N _____	Genetic	Y / N _____
Hypertension	Y / N _____	Kidney Disease	Y / N _____	Heart Disease	Y / N _____
Migraines	Y / N _____	Nerve/Muscular	Y / N _____	Psych. Disorders	Y / N _____
ADHD	Y / N _____	High Cholesterol	Y / N _____	Obesity	Y / N _____

Other: _____

None of the above:

Name: Mother _____ Father _____

Occupation/Employer : Mother _____ Father _____

Social Security Number: Mother _____ Father _____

Form completed by: _____ Date: _____

Reviewed by: _____ Date: _____ Chart # _____