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