happy kids pediatrics

Health History English

Name of patient:_____ Date of Birth_____ Sex M / F Race_____ Allergies_____
Please list all people in household-

Father_____DOB_____Occupation_____Education_____

Mother_____DOB_____Occupation_____Education_____

Other_____DOB_____Occupation_____Education_____

Other_____DOB_____Occupation_____Education_____

Other_____DOB_____Occupation_____Education_____

Birth History- Birth weight_____Length_____Hospital_____ Vaginal // C-section // Breech (Circle one)
During pregnancy did the use one or more of the following, cigarettes, alcohol, medication,. Please explain in space provided.

_____
_____
_____

Past Medical History- Is the child in -- GOOD // FAIR // POOR Health? Is the Child Taking any Medication Y // N. Please list hospitalizations, operations, serious illnesses and or accidents with dates.

_____
_____
_____

Has the child had any problems with one or more of the following? Please circle Y or N. (If Yes please provide more detail below.)

(Physical)

Eyes/ Vision	Y/N	Feet	Y/N	Digestion/Nutrition	Y/N	Ears/Hearing	Y/N	Urine/Kidney	Y/N
Joints	Y/N	Skin	Y/N	Lungs	Y/N	Teeth	Y/N	Heart	Y/N
Seizures	Y/N	Exposed to Cigarette smoke	Y/N	Take any medications	Y/N

(Developmental)

Behavior Y/N Eating habits Y/N Sleeping Habits Y/N School experience Y/N Discipline Y/N
Bathroom/Toilet Habits Y/N

_____
_____
_____

Family History

Are any of the child's siblings deceased? Y/N If yes, list age and cause_____
Have any of the child's blood relatives had any of the following diseases? If Yes list family member.

Heart Disease Y/N _____Tuberculosis Y/N _____High Blood Pressure Y/N _____
Kidney Disease Y/N _____Allergies/Asthma Y/N _____Cancer Y/N _____
Diabetes Y/N _____Mental Health Issues Y/N _____Sickle Cell Y/N _____
Seizures Y/N _____

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Health History English

This Section is for teenagers, to be filled out by the Teen.

Do you : Use tobacco Y/N Drink Beer or alcoholic beverages Y/N Use any Kind of Drug Y/N

Are you sexually active Y/N If Yes Do you use birth control Y/N Have you ever been pregnant or fathered a child Y/N

For females—How old were you when you had your first period?_____

Do you have any concerns about the following---Safety issues Y/N Substance Use Y/N STD's Y/N Family Planning Y/N

Other please explain_____