FALLBROOK FAMILY HEALTH CENTER, LLC

PEDIATRIC HISTORY FORM

Name _____ Date _____

Date of Birth _____ Place of Birth _____

Birth weight _____ Length _____ Delivered by _____

Parents' names: _____

Parents' Marital status: (circle one) Married Divorced Separated Never married

List of all those living in household and relationship to patient: _____
_____

PREGNANCY INFORMATION:
Any complications during pregnancy, labor, delivery, or hospital stay:
_____
_____

FEEDING HISTORY: Breast _____ Formula type_____
Solids (identify) _____ Vitamins _____
Fluoride supplement or tap water yes no

ALLERGIES: Foods _____ Medications _____
Other _____

MEDICATIONS: _____

OPERATIONS:

Type	Date Performed	Hospital	Surgeon

HOSPITALIZATIONS:

Diagnosis	Date	Hospital	Physician

SERIOUS INJURIES OR ACCIDENTS AND DATES: _____
_____
_____

DAY CARE: Home based Center based

EXPOSURE TO CIGARETTE SMOKE: Yes No

FIREARMS IN HOME: Yes No

IMMUNIZATIONS: (List Dates)

	#1	#2	#3	#4	#5
DTaP					
Polio					
HIB					
Prevnar					
Hep B					
Gardasil (HPV)					
Varicella					
MMR					
Hep A					
Menactra (MCV)					

Seasonal Influenza date of immunization: _____

DEVELOPMENTAL: Age child: Sat up _____ crawled _____ walked _____
Toilet trained _____ talked in phrases _____

REVIEW OF SYSTEMS:
Does your child have, or has he/she ever had: (circle yes or no)

INFECTIOUS DISEASE
Chicken pox yes no
If yes, when: _____
HIV/AIDS yes no
Sexually transmitted disease yes no

ENT
Frequent ear infections yes no
Problems with hearing or ears yes no

EYES
Problems with eyes or vision yes no

RESPIRATORY
Asthma yes no
Frequent bronchitis or pneumonia yes no
Recurrent croup yes no
Tuberculosis or positive TB skin test yes no

PSYCHIATRIC
Other chronic or serious lung disease yes no
Emotional disorder or suicide attempts yes no
Behavior disorder (ADHD, ODD) yes no
Psychiatric disorder yes no
Use of alcohol or drugs yes no

HEMATOLOGY
Anemia or bleeding problem yes no
Blood transfusion yes no
Cancer yes no
Other yes no

GASTROINTESTINAL
Frequent abdominal pain yes no
Constipation requiring doctor visits yes no

GENITOURINARY
Bladder or kidney infection yes no
Bed-wetting (after 5 years old) yes no

ENDOCRINE
Thyroid or other endocrine problem yes no
Diabetes yes no

SKIN
Any chronic or recurrent skin problem yes no
(acne, eczema, etc.)

NEUROLOGIC
Frequent headaches yes no
Convulsions or other neurologic problem yes no
Concussion yes no

CARDIAC
High blood pressure yes no
High cholesterol yes no
Heart murmur yes no
Congenital or acquired heart defect yes no

GENITOURINARY
(For girls) Has she started her menstrual period? yes no
(For girls) Are there problems with her periods? yes no

Please explain any yes answers: _____

_____

_____

FAMILY HISTORY	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers/sisters				
1.				
2.				
3.				
4.				

Has any blood relative ever had:	YES	NO	Relationship (check what applies)	Age at Onset
Cancer Type of Cancer:			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Heart trouble			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Diabetes			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Stroke			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
High blood pressure			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Thyroid problem			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Anesthesia or malignant hyperthermia problems			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Bleeding or blood clotting problems			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	
Other			□ Maternal grandmother □ Paternal grandmother □ Maternal grandfather □ Paternal grandfather □ Other _____	