DAN R. BAKER, MD

Pediatric Health History

(5 - 15 years and older)

Name: ____ Date of Birth: ____/____/______ Sex: M F

Person completing form & relationship to patient: ______________________________________

Check all items that apply to your child and fill in blanks as needed. Please complete all sections.

Past Medical History: (Please include dates)

Was child: o Full term *or* o Premature (______weeks) Type of delivery: o vaginal o C-section

- o Acne
- o ADD
  - o ADHD
- o Allergies(other than drug)____________
- o Anemia
  - o Other blood problems
- o Anesthesia complications
- o Arthritis, rheumatoid
- o Asthma
  - o Other lung disease
- o Birth defects
- o Cancer/Tumor, explain:_____________
- o Chicken pox, year of illness___________
- o Depression
  - o Anxiety
  - o Suicide attempts
- o Diabetes, type 1
  - o Type 2, how long:__________________
- o Drug abuse
  - o Alcohol abuse
- o Ear infections
- o Eating disorder, ______________________
- o Epilepsy (seizures)
- o Headaches, type:______________________
- o Head injury
- o Hearing loss
  - o Deafness
- o Heart problems
  - o Murmur
- o High blood pressure
- o HIV or AIDS
- o Hypothyroid (low)
  - o Hyperthyroid (high)
- o Kidney disease
- o Learning disability
- o Measles
- o German measles
- o Mumps
- o Menstrual problems
- o Pneumonia
- o Psychiatric treatment, in-patient or out-patient: ___________________________
- o Rheumatic fever
  - o Scarlet fever
- o Sexually transmitted disease (STD)_______
- o Skin disease
  - o Eczema
  - o Psoriasis
- o Strep throat
- o Tuberculosis (TB), last chest x-ray_______
- o Whooping cough
- o Other: ____ ____

Females only> Number of : Pregnancies ______ Live Births ______ Miscarriages_____ Abortions_____
Age at first period _____years old, Birth control method__________________________

Past Surgical & Hospitalization History: (Please include dates) **o N/A**

- o Appendectomy ____________________
- o Ear tubes___________________________
- o Fracture ___________________________
- o Hernia, R or L, type ____________________
- o Tonsillectomy ________________________
  - o Adenoidectomy ____________
- o Other ___________________________________

Procedures > Date of last: EKG ________ Colonoscopy _________ Eye exam ________ Stress test _________
Females only > Date of last: Pap Smear_______ Mammogram_________ Bone density____________
Males only > Date of last: Physical exam________ Prostate exam_________ PSA__________

Current specialists: ____

Previous physicians: ____

Child's Name: ___________________________________

Drug Allergies: o No Known Drug Allergies

Name of Drug	Reaction

Current Medications: (prescriptions, birth control pills, over-the-counter, herbs, vitamins):

Medication	Strength/Dose	Frequency	Medication	Strength/Dose	Frequency

Immunizations:

Are your child's immunizations up-to-date? o NO o Yes Please attach a copy of his/her vaccine record. ***If not available today, please provide record by next visit.***

Social History:

Child's parents are: o Married o Divorced o Single o Separated o Widowed

Child lives with: ____

Please check appropriate spots for each of the following items:

Tobacco use: o No o Yes (o Cigarettes o Chew/snuff , ? per day_____; how long___) o Quit, when______

Alcohol use: o No o Yes (Quantity: number of drinks or bottles of beer per week___________________)

Caffeine: o No o Yes (Quantity: number of cups/glasses/cans per day of coffee, tea or soda ______________)

Recreational drugs: o No o Yes (what drugs do you use________________________________)

Sexually Active: o No o Yes

Seat Belt Use: o No o Yes

Family History:

	Living		Deceased	
	Age	Health Status or Illnesses	Age	Cause of death & Illnesses
Father				
Mother				
Father's father				
Father's mother				
Mother's father				
Mother's mother				
Brothers				
Sisters				

o Child is adopted – Family history unknown

Patient Signature: ____Date: _____/_____/_______

Provider Reviewed: ____Date: ____/_____/_______