

## Fishers Family Care Health History Form Pediatric (Newborn to 10 Years Old)

Patient Name:	DOB:	Today's Date:
Parent/Guardian Name(s):		
Current Medications:		
Allergies:		
Surgeries/Hospitalizations/Major Illnesses (include age and/or date):		

### Medical History

Birth weight: \_\_\_\_\_

Was the delivery  Vaginal?  Cesarean?

Was the baby born at term? \_\_\_\_\_ Early? \_\_\_\_\_ Late? \_\_\_\_\_

If cesarean, why? \_\_\_\_\_

If early, how many weeks' gestation? \_\_\_\_\_

Did your baby have any problems right after birth?

Did the mother have any illness or problem with her pregnancy?  
 Yes  No Explain \_\_\_\_\_

Yes  No Explain \_\_\_\_\_

During pregnancy, did the mother  
 Smoke  Yes  No Drink alcohol  Yes  No  
 Use drugs or medications  Yes  No  
 What \_\_\_\_\_ When \_\_\_\_\_

Was initial feeding  Breast?  Bottle?

Did the baby go home with mother from the hospital?  
 Yes  No Explain \_\_\_\_\_

### Past Medical History

Chicken Pox  Yes  No When \_\_\_\_\_

Mumps  Yes  No When \_\_\_\_\_

Measles  Yes  No When \_\_\_\_\_

Meningitis  Yes  No When \_\_\_\_\_

Rubella  Yes  No When \_\_\_\_\_

Diabetes  Yes  No Explain \_\_\_\_\_

Asthma, bronchitis, bronchiolitis or pneumonia  Yes  No Explain \_\_\_\_\_

Frequent ear infections  Yes  No Explain \_\_\_\_\_

Problems with ears or hearing  Yes  No Explain \_\_\_\_\_

Nasal allergies  Yes  No Explain \_\_\_\_\_

Recurrent strep throat  Yes  No Explain \_\_\_\_\_

- Problems with eyes or vision  Yes  No Explain \_\_\_\_\_
- Any heart problem or heart murmur  Yes  No Explain \_\_\_\_\_
- Bladder or kidney infection  Yes  No Explain \_\_\_\_\_
- Any chronic or recurrent skin problem (acne, eczema, etc.)  Yes  No Explain \_\_\_\_\_
- (For girls) Has she started her menstrual periods?  Yes  No Explain \_\_\_\_\_
- (For girls) Are there problems with her periods?  Yes  No Explain \_\_\_\_\_
- Bed-wetting (after 5 years old)  Yes  No Explain \_\_\_\_\_
- Frequent headaches  Yes  No Explain \_\_\_\_\_
- Convulsions or other neurological problem  Yes  No Explain \_\_\_\_\_
- Failure to thrive  Yes  No Explain \_\_\_\_\_
- Use of alcohol or drugs  Yes  No Explain \_\_\_\_\_
- Any other significant problem  Yes  No Explain \_\_\_\_\_

**Family/Social History**

Please list all those living in the child's home and any immediate family members not living in the home

Name	Relationship to Child	Age	Living in the Home	Health Problems

If both parents work, who provides child care?  Day Care Center  Sitter in the Home  Relative  Other \_\_\_\_\_

Are there any family members living with the child who smoke?  Yes  No

What type of water is used in the home?  City  Well

**Do any of the patient's family members have any of the following? If so, check the appropriate box and write the family member.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma _____       | <input type="checkbox"/> Febrile Seizures _____      | <input type="checkbox"/> Bleeding Disorders _____  |
| <input type="checkbox"/> Emphysema _____    | <input type="checkbox"/> Thyroid Disease _____       | <input type="checkbox"/> SIDS (crib death) _____   |
| <input type="checkbox"/> Epilepsy _____     | <input type="checkbox"/> Heart Diseases/Attack _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Diabetes _____     | <input type="checkbox"/> Mental Retardation _____    | <input type="checkbox"/> High Cholesterol _____    |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Genetic Disease _____       | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Stroke _____       | <input type="checkbox"/> Cancer (include type) _____ | _____  |

Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_