Capital Family Physicians, P.A.
2417 Atrium Drive, Suite 201
Raleigh, NC 27607

Date: _____ Physician: _____

PEDIATRIC HEALTH HISTORY ASSESSMENT

Name: _____ Nickname/Preferred Name: _____

Date of Birth: _____ Birth Weight: _____ Birth Length: _____

List Allergies (Medicine, Food, Asthma, Hayfever, Latex, etc.) / Reactions: _____

_____

_____

Current Medications (List any that he/she may be taking.)

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

Family History: (Relative)

- ☐ Allergies
- ☐ Asthma
- ☐ TB
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Sickle Cell
- ☐ Mental Illness

Childhood Illness:

- ☐ Measles
- ☐ Whooping Cough
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Broken Bones
- ☐ Headaches
- ☐ Seizures
- ☐ Pneumonia
- ☐ Hospitalization _____
- ☐ Asthma
- ☐ Frequent Ear Infections
- ☐ Mental Illness
- ☐ Congenital Abnormalities
- ☐ Known Inheritable Conditions/Diseases
- ☐ Suicide
- ☐ Alcoholism

Current Immunization Reaction:

	Yes	No	N/A	Yes*	No
DPT	☐	☐	☐	☐	☐
OPV	☐	☐	☐	☐	☐
MMR	☐	☐	☐	☐	☐
HIB	☐	☐	☐	☐	☐
Hep.	☐	☐	☐	☐	☐

*If yes, describe: _____

_____

Comments: _____

_____

	YES	NO	COMMENTS
1. Any problems with pregnancy?	☐	☐	_____
Length of pregnancy _____ ☐ Early ☐ On time ☐ Late ☐ C-section ☐ Induced			
2. Any problems with labor?	☐	☐	_____
3. Any problems during delivery?	☐	☐	_____
4. Any problems in first month of life?	☐	☐	_____
5. Has he/she been hospitalized?	☐	☐	_____
6. Has he/she had any surgery/operations?	☐	☐	_____
7. Has he/she had a serious accident?	☐	☐	_____
8. Has he/she had any broken bones?	☐	☐	_____
9. Has he/she failed any grades	☐	☐	_____
10. Has he/she experienced any problems in school?	☐	☐	_____
11. Any firearms in the house?	☐	☐	_____
12. Does he/she drink well water?	☐	☐	_____
13. Any exposure to lead?	☐	☐	_____
14. Smoker in the home?	☐	☐	_____
15. Pets in the home?	☐	☐	_____

DEVELOPMENTAL: Please complete this section for children 6 years of age and under.

List approximate ages at which your child first accomplished the following:

Rolled Over _____ Crawled _____ Said First Sentences _____ Climbed Stairs _____

Sat Up _____ Walked Alone _____ Said Sentences _____ Toilet Trained _____

- OVER -

PEDIATRIC HEALTH HISTORY ASSESSMENT (Cont.)

NUTRITIONAL

Diet: Type: _____ ☐ Special Formula/Diet Needs

Comments: _____

☐ Feeds Self ☐ Needs Assistance with Meals ☐ Needs to be Fed ☐ Table Foods ☐ Baby Foods ☐ Cup

☐ Bottle ☐ Breast Feeding Comments: _____

Any problem with: Eating/Drinking in Recent Weeks? ☐ No ☐ Yes With swallowing? ☐ No ☐ Yes

Comments: _____

ACTIVITY/EXERCISE

☐ Walks Alone ☐ Walks with Assistance ☐ Stands Alone ☐ Sits Alone ☐ Assistive Devices _____

Limitations ☐ None ☐ Yes: _____

Weaknesses ☐ None ☐ Yes: _____

Joint Problems ☐ None ☐ Yes: _____

SLEEP/REST

☐ Sleeps Alone ☐ Sleeps through the Night Naptime _____ Bedtime _____

Any Sleep Pattern Changes? ☐ No ☐ Yes

COGNITIVE/PERCEPTUAL

Developmental Level: Normal for Age ☐ Yes ☐ No Primary Language _____

☐ Right Handed ☐ Left Handed ☐ Reads ☐ Writes

Difficulty With: Speech ☐ No ☐ Yes: _____

Hearing: ☐ No ☐ Yes: _____ Aids ☐ R ☐ L ☐ Signs ☐ Cued ☐ Reads Lips

Vision: ☐ No ☐ Yes: _____ ☐ Glasses ☐ Contacts

If communication is difficult, how do we best communicate? _____

How do you (parent) learn best? ☐ Reading ☐ TV/Video ☐ Demonstration ☐ Listening ☐ Doing

ROLE/RELATIONSHIP

Legal Guardian _____ Lives With: _____

Mother's Last Name _____ Father's Last Name _____

☐ Stays at Home ☐ Day Care ☐ School/Grade _____ # of Siblings in Household _____

Parents: ☐ Married ☐ Single ☐ Divorced ☐ Separated

COPING/STRESS TOLERANCE

Major Changes in Last 1-2 years: ☐ No ☐ Yes _____

Reaction to New Situations _____

Reaction to Discomfort/Pain _____

What Comforts Your Child _____

Child's Habits: ☐ Pacifier ☐ Thumbsucking ☐ Security Blanket/Object ☐ Favorite Toy _____

☐ Bed Wetting ☐ Nightmares ☐ Temper Tantrums

VALUES/BELIEFS

Religion _____

Special Request Due to Religious Practices/Values: ☐ None ☐ Special Diet ☐ Blood Transfusion ☐ Baptism

☐ Annointing of Sick ☐ Circumcision ☐ Jewish Sabbath Basket

SELF CONCEPT

Child is usually: ☐ Happy ☐ Fussy ☐ Active ☐ Talkative ☐ Quiet

Completed By: _____ Relationship to Patient: _____