

Premier Pediatrics of Palm Beach
Pediatric Health History Form – Initial Visit

Child's Name _____ DOB _____ Age _____ Today's Date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by birth adoption stepchild other

Delivery: Vaginal C-section

Was your child premature? No Yes, born at ___ weeks

Birth Weight _____

Problems in the newborn period

Infancy/Childhood/Adolescence

Has your child ever been treated or diagnosed with (explain)

Asthma or reactive airway disease _____

Wheezing or bronchiolitis _____

Seasonal Allergies _____

Eczema _____

Food Allergy _____

Recurrent ear infections _____

Pneumonia _____

Urinary Tract Infections _____

Seizures _____

Anemia _____

Broken Bone _____

Depression/Anxiety _____

Heart Murmur _____

Constipation _____

Chicken Pox _____

Attention Deficit Disorder _____

Other Chronic Medical Conditions _____

Has your child ever been hospitalized? No Yes (explain)

Past surgeries or procedures? _____

Please list any specialist your child has seen, dates, and reason: _____

Medications

Please list ALLERGIES to any medicines

Current Medications

Any concerns about your child's development/nutrition? _____

Name of School or Daycare NONE _____

Social History

Who lives in the child's household? Mom Dad Step _____

Siblings (# _____) Grandparents Other _____

Childs Parents are married unmarried divorced other

Mom's Occupation _____ Dad's Occupation _____

Do any household members smoke? Yes No

Family History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Issues:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain all positives: _____

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