METROPOLITAN ELITE FAMILY PRACTICE, LLC
PEDIATRIC HEALTH HISTORY FORM

CHILD'S NAME: ____ DATE OF BIRTH: _____/____/______
(Last) (First) (M.I) (Month) (Day) (Year)

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: ____

PRESENT HEALTH CONCERNS: ____

____

MEDICINES/VITAMINS: ____

HERBS/HOME REMEDIES: ____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: ____

PREGNANCY & BIRTH: BIRTH PLACE: ____

Is this child yours by: ☐ birth ☐ adoption ☐ stepchild ☐ other ______________________________

Please indicate any medical problems during pregnancy ☐ none ☐ specify: ____________________

____

Delivery by: ☐ vaginal birth ☐ c-section If c-section, why? __________________________________

Birth weight: _____________ Birth length: _____________ APGAR score 1min________ 5 min ________

Please indicate any medical problems during the baby's newborn period: ☐ none

If premature, how early? _________other problems: ____

____

NUTRITION & FEEDING

Has your child had any unusual feeding/dietary problems? ☐No ☐Yes If yes, specify: ___________

____

Milk intake: Type: ☐cows milk (☐non-fat, ☐ 1%fat, ☐2%fat, ☐ whole milk) ☐ soy milk, ☐ rice milk

Average ounces per day (Note: 8 ounces are in 1 cup) _______________

SLEEP

Hours per night ______ Any sleep problems? ____

DEVELOPMENT

At what age did your child: sit alone_____ walk alone_____say words______toilet train (day) ________

Girls only: Age of first menstrual period ______________

DENTAL HISTORY: Has child been seen by a dentist? ☐ Yes ☐ No If so, how often _____Date of last visit______

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.

Has your child had: ☐chicken pox ☐measles ☐mumps ☐rubella ☐meningitis ☐tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) ☐ No ☐ Yes

Do any household members smoke? ☐No ☐Yes

TV ---hours per day _______ Computer---hours per day _______ Video Games---hours per day ______

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates

____

____

____

Hospitalizations/Operations (with dates): ____

Broken bones or severe sprains ____

FAMILY HISTORY: Please circle any family history of the following (indicate who has/had the condition) (use back if needed)

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited genetic diseases	Cancer

SOCIAL HISTORY: Who lives at home?

Name	Age	Relationship	Highest Education Level
________________________	_______	____________________	____________________
________________________	_______	____________________	____________________
________________________	_______	____________________	____________________
________________________	_______	____________________	____________________
________________________	_______	____________________	____________________

Are the child's parents ☐married ☐unmarried ☐separated ☐ divorced I fdivorced, when? _______

Parents' occupations: Mother ________________________ Father ____________________________

Child care situation ☐parents ☐others (specify who and hours per day) ______________________

____

Concerns about your child: ☐Alcohol use ☐Tobacco ☐Sexual Activity ☐Aggressive Behavior

Is violence at home a concern? ☐No ☐ Yes Are there guns in the home? ☐No ☐Yes

SCHOOL HISTORY:

Did/does your child attend school? ☐ No ☐ Yes Current grade _______Name of school __________

Any concerns about school performance? ____

Any concerns about relationships with Teachers ☐ No ☐ Yes _______________________________

Students ☐ No ☐ Yes _______________________________

If over 4 years old, does your child have a best friend? ☐ No ☐Yes

Sports/exercise: Type ________________How often? ________________How long (minutes)_________

REVIEW OF SYSTEMS: Please check all that apply to your child.

☐ Fevers/chills/excess sweating
☐ Unexplained weight loss/gain
☐ Squinting/"crossed" eyes/ assymetric gaze
☐ Unusually loud voice/hard of hearing.
☐ Mouth breathing/snoring
☐ Bad breath
☐ Frequent runny nose
☐ Problems with teeth/gums
☐ Cough/wheeze

☐ Nausea/vomiting/diarrhea
☐ Constipation
☐ Blood in bowel movement
☐ Tires easily with exertion
☐ Shortness of breath
☐ Fainting
☐ Bedwetting
☐ Pain with urination
☐ Discharge: penis or vagina
☐ Headaches
☐ Weakness
☐ Clumsiness
☐ Muscle/joint pain

☐ Hayfever/itchy eyes
☐ Rashes
☐ Unusual moles
☐ Speech Problems
☐ Anxiety/stress
☐ Problems with sleep/nightmares
☐ Depression
☐ Nail biting/thumb sucking
☐ Bad temper/breath holding/jealousy
☐ Unexplained lumps
☐ Easy bruising/bleeding

Parent/Guardian
Signature: ________________________________Date: ____________

Provider
Signature: ___________________________________Date: _____________