Date____/____/____ **INITIAL PEDIATRIC HEALTH HISTORY**

SOCIAL HISTORY

Name:_____ **Date of Birth**____/____/____ **Place of Birth:**_____

Sex: □ **Male** □ **Female** **Language Spoken at Home**_____

Name of Mother:_____ **Address**_____

Name of Father:_____ **Address**_____

Occupation of Mother: _____ **Occupation of Father:**_____

FAMILY HISTORY

Please list your family members below:

Name	Age	Health Problems

Are there any blood relatives who have ever had any of these problems? :

□ High Blood Pressure □ Sickle Cell Disease
□ Diabetes □ High Blood Cholesterol
□ Tuberculosis □ Hyperactivity
□ Asthma □ Cancer
□ Seizures □ Birth Defects
□ Mental retardation

Comments:_____

BIRTH HISTORY

Name and Address of Hospital _____
Problems during pregnancy_____
Birth Weight_____ **Type of Delivery:** □ **Vaginal** □**Cesarean Section**
Problems during or immediately after birth _____
Went home after_____**(number of) days.** **Type of Food:** □ **Breast Milk** □ **Formula**

DEVELOPMENT

Please write age at which your child first began to: **Sit alone:**_____ **Walk alone:**_____ **Use Single words:**_____ **Toilet Trained:**_____

Any school problems now or in the past? _____

Name of present school _____

MEDICAL HISTORY

List ant major illnesses, operations, or hospitalizations below **Dates**

1._____ _____

2._____ _____

3._____ _____

ALLERGIES

List any reactions your child has had to foods, medications, or Insects below:

_____

_____

Reviewed by:_____ **Date Reviewed:**_____/_____/_____