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

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:**______/______/______