

Health History Information

Wheaton Pediatrics, Ltd.

Today's date: _____

Patient's Name _____ Male ___ Female ___ Date of Birth _____

Place of Birth _____ Hospital Home Other _____

Parent or Guardian's Name _____ Biologic Adoptive Foster Parent Other

Prior physician's and location/s of office/s _____

****PLEASE NOTE:** This form is for all new incoming patients. Not all questions are appropriate for newborns. If your child is a newborn, leave areas blank that don't seem appropriate.

GENERAL HEALTH HISTORY:

- Medications-Please list all medications your child is currently taking.

- Allergies/Sensitivities-Please list all allergies, how your child reacts, and when each allergy started.

- Family Health:

Please give the following information about your child's immediate family:

<u>Relationship</u>	<u>Age, if living</u>	<u>Age at death</u>	<u>State of Health or cause of death</u>
Father.....	_____	_____	_____
Mother.....	_____	_____	_____
Siblings (please state name and if M or F)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any blood relatives had any of the following illnesses? If so, indicate relationship to the child.

<u>Illness</u>	<u>Family Members</u>	<u>Illness</u>	<u>Family Members</u>
Asthma.....	_____	Rheumatoid Arthritis.....	_____
Hay fever, Eczema.....	_____	High Blood Pressure.....	_____
Other allergies.....	_____	Heart Disease/Attacks...	_____
Diabetes.....	_____	High Cholesterol.....	_____
Cancer.....	_____	Thyroid Disease.....	_____
Blood disease/Bleeding Tendencies	_____	Mental Retardation.....	_____
Seizure disorder/epilepsy.....	_____	Mental Disease/Disorder/Depression	_____
Birth Defects.....	_____		_____
Tuberculosis.....	_____	SIDS/Crib death.....	_____
Other.....	_____		_____

- HOSPITALIZATIONS, SURGERIES, INJURIES:

Please list all times, if any, that your child has been seriously ill, injured, hospitalized/or operated on.

<u>Year</u>	<u>Operation, Illness, Injury</u>	<u>Hospital/City, if applicable</u>
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Patient's Name _____ Date of Birth _____

• IMMUNIZATIONS:

To your knowledge, are your child's immunizations up to date? ڻ Yes ڻ No

**Please obtain a copy of your child's previous records for our chart.

PRENATAL, DELIVERY, AND POSTNATAL INFORMATION:

Prenatal Care?.....ڻ Yes ڻ No When was it started? _____

Any illness during pregnancy?.....ڻ Yes ڻ No If yes, describe _____

Was baby born on time?.....ڻ on time ڻ early ڻ late _____

Birth Weight..... lbs. oz.

Apgar Scores, if known.....

How delivered..... ڻ vaginal ڻ C-section

Any complications?.....

How was baby's health during its first week?.....ڻ excellent ڻ good ڻ fair ڻ poor

If problems, circle from following description.....blue – jaundiced (yellow) – breathing problem

Oxygen used – infection – birth defect

Transfusion – other _____

If the baby was jaundiced, was treatment needed (bili blanket)? ڻ Yes ڻ No

Did the baby remain in the hospital longer than mom?.....ڻ Yes ڻ No If yes, please elaborate _____

CHILD'S HEALTH PRIOR TO THIS VISIT, if applicable:

Has your child been seen at regular intervals by a physician/nurse practitioner? ڻ Yes ڻ No

Breastfed? If so, how long?.....ڻ Yes _____ ڻ No

If no, what formula, how long and any problems? _____

Please circle applicable problems in infancy from the following.....Colic – feeding problems – rashes

Excessive crying – spitting up

Diarrhea – nasal congestion

Other _____

Please circle applicable problems in childhood from the following...Chronic colds – ear infections – croup

Asthma – strep throat – anemia

Eczema – stuttering - ADHD

Discipline problems – dental problems

Other _____

Has your child had chickenpox?.....ڻ Yes ڻ No Date _____

How would you categorize your child's development? ڻ At least normal ڻ Delayed If delayed, please elaborate _____

Does your child have any feeding or nutritional problems?.....ڻ Yes ڻ No

If yes, please elaborate _____

What kind of water does your child drink? ڻ City ڻ Well ڻ Regular bottled ڻ Bottled nursery water

Does your child take vitamins of any kind? ڻ Yes ڻ No If yes, please elaborate _____

Is there any other information you would like us to know about your child?

Thank you for completing this questionnaire.

Parent/Guardian signature: _____

Physician/Nurse Practitioner Notes: