WELLSTAR Health System

Patient Name_____ Date of Birth:_____

PEDIATRIC PATIENT HISTORY FORM

BIRTH HISTORY

Delivery: ☐Vaginal ☐Cesarean – due to:	Birth Weight:
Was this child premature? ☐Yes ☐No If yes, how many weeks?_____	Were there problems with this child's delivery? ☐Yes ☐No If yes, list:
Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? If yes, please list:	
Did this child need special treatment while in the hospital such as oxygen, transfusions, lights?	
Was (is) this child breast fed? ☐ No ☐Yes	
Did (does) this child have any problems with breast formula feeding?	

SOCIAL HISTORY (Circle the appropriate answers)

Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Single	
Siblings – please list:	
How many people live in your home? _____ Adults _____Children	
Is your child currently enrolled in daycare or school? ☐No ☐Yes	
Does your child participate in regular exercise? ☐ No ☐Yes explain:	
Does your child drink caffeine? ☐No ☐Yes	
Is there a swimming pool at home? ☐No ☐Yes	Any smokers at home? ☐No ☐Yes
Are there smoke detectors at home? ☐No ☐Yes	Carbon Monoxide detectors? ☐No ☐Yes
Any pets at home? ☐No ☐Yes If yes, please list:	
What is your water source?	Are guns kept in your home ☐Yes ☐No
Do all family members use Seat belts/care safety sets? ☐No ☐Yes	Do all family members use Helmets when biking? ☐No ☐Yes
Any issues we should be aware of? ☐No ☐Yes Please list:	

Provider Initials:_____ Date:_____

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MEDICAL HISTORY

Hospitalizations? ☐None ☐Yes-list:	
Surgeries? ☐None ☐Yes-list:	
Drug Allergies? ☐None ☐Yes-list:	
Did you bring a copy of child's immunization record? ☐No ☐Yes If no, please provide as soon as possible.	Hepatitis B Vaccine? ☐No ☐Yes
Has your child had chicken pox? ☐No ☐Yes	Has your child had chicken pox vaccine? ☐No ☐Yes
Any Chronic Illnesses: none yes-list:	Has your child seen a sub-specialist? ☐No ☐Yes If yes, who?

REVIEW OF SYSTEMS

Any lung problems?	None	Yes-list:
Any heart problems?	None	Yes-list:
Any kidney/urinary problems?	None	Yes-list:
Any bone/muscle problems?	None	Yes-list:
Any gastro-intestinal problems?	None	Yes-list:
Any brain/nervous system problems?	None	Yes-list:
Any genital problems?	None	Yes-list:
Any skin problems?	None	Yes-list:
Any eye/ear /nose/throat problems?	None	Yes-list:
Any developmental concerns or learning problems?	None	Yes-list:
Any behavioral problems or eating disorders	None	Yes-list:
Any regular prescription or over the counter medications (include dose and frequency?		
Any medical issues we should be aware of? None Yes-list:		

Provider Initials: _____ Date:_____

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FAMILY MEDICAL HISTORY

	Child's Father	Child's Mother	Sibling	Sibling	Grandparent	Other
Year of Birth (if known)						
Year of Death (if known)						
Cause of Death (if known)						
Heart Disease						
High Blood Pressure						
Stroke						
High Cholesterol						
Anemia						
Diabetes (note if onset as Adult or Child)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Social Problems						
Psychiatric Problems						
Cancer (type)						
Kidney Disease						
Migraines						
Seizures						
Congenital Birth Defects						
Eating Disorder						
Other:						
Other:						

COMMUNICATION NEEDS:

Language if other than English: Child_____ Parent(s)_____
Any special communication needs? ☐No ☐Yes
If yes, explain: _____

PATIENT EDUCATION ASSESSMENT:

Would you prefer patient education be provided to you or your child by:

- ☐ Demonstration
- ☐ Written Materials
- ☐ Other Explain: _____

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for your child? ____Y ____N
If YES, explain:_____

Provider Signature:_____ Date:_____