



PEDIATRIC ASSOCIATES

GENERAL HEALTH HISTORY (3-11 YEARS OLD)

Please complete each section of the patient's health history. **ALL ITEMS MUST BE COMPLETED.**

PATIENT'S NAME:	PATIENT'S DATE OF BIRTH:	TODAY'S DATE:
MEDICAL HISTORY		
Has your child ever had a urinary tract infection? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, at what age?		
Has your child ever been diagnosed with asthma or wheezing? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, at what age?		
Has your child ever had any medical problems? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify:		
Has your child ever had any fractures, concussion, or other serious injuries? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify what and at what age?		
Does your child have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify?		
Does your child see any specialists? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, who?		
Has your child ever received occupational, physical or speech therapy(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify which therapy(s) and why:		
Surgeries or hospitalizations (where the child was admitted to the hospital):		
Age:	Reason:	Age: Reason:
FAMILY HISTORY		
Does anyone in your family listed below have any chronic diseases/illnesses such as diabetes, heart attacks, strokes, depression, asthma, cancer or thyroid issues or any other diseases/illnesses we should know about? Please check alive or deceased or other for each family member listed above and if there are no health issues, check healthy.		
If unable to complete this section, please let us know why: <input type="checkbox"/> Adopted Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Other _____		
Father: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Healthy <input type="checkbox"/> Disease/Illness Explain:		
Mother: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Healthy <input type="checkbox"/> Disease/Illness Explain:		
Sibling: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Healthy <input type="checkbox"/> Disease/Illness Explain:		
Father's Father: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Healthy <input type="checkbox"/> Disease/Illness Explain:		
Father's Mother: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Healthy <input type="checkbox"/> Disease/Illness Explain:		
Mother's Father: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Healthy <input type="checkbox"/> Disease/Illness Explain:		
Mother's Mother: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Healthy <input type="checkbox"/> Disease/Illness Explain:		
SOCIAL HISTORY		
Home situation: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Adopted <input type="checkbox"/> Relative <input type="checkbox"/> Foster Care		
Parents' marital status: <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Childcare? <input type="checkbox"/> None <input type="checkbox"/> Relative <input type="checkbox"/> Private Sitter <input type="checkbox"/> Daycare		
Pets? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Smoke/CO detectors in the home? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Passive smoke exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> Outside? <input type="checkbox"/> Inside?		
Grade in school:		Name of school: