Dakota Child and Family Clinic
2530 Horizon Drive
Burnsville, MN 55337

____
Name (optional)

Pediatric Health History Form

CHILD'S NAME: ______________________ DATE OF BIRTH: ____________ AGE: ____
CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: ______________________
PRESENT HEALTH CONCERNS: ______________________
____
MEDICINES/VITAMINS: ______________________
HERBS/HOME REMEDIES: ______________________
ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: ______________________
____

PREGNANCY & BIRTH

Where was your child born? ______________________
Is the child yours by: ❑ Birth ❑ Adoption ❑ Stepchild ❑ Other: ____________
Please indicate any medical problems during pregnancy ❑ None ❑ Specify: ____________
____
Delivery by ❑ Vaginal birth ❑ Caesarean If Caesarean, why? ____________
Birth weight: ____________ Birth length: ____________ APGAR score 1 min ___ 5 min ___
Please indicate any medical problems during the baby's newborn period ❑ None If premature, how early? _____
Other problems: ______________________
____

NUTRITION & FEEDING

Was your child breastfed? ❑ No ❑ Yes If so, how long? ____________
Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify: ____________
____
Milk intake now: Type ❑ Cow's milk (❑ Nonfat ❑ 1% fat ❑ 2% fat ❑ Whole milk) ❑ Soy milk ❑ Rice milk
Average ounces per day (Note: 8 ounces = 1 cup)________

SLEEP

Hours per night__________ Naps (number & length)____________
Any sleep problems? ______________________

DEVELOPMENT

At what age did your child: Sit alone_____ Walk alone_____ Say words_____ Toilet train (daytime)_____
Girls only: Age at first menstrual period_____

DENTAL HISTORY: Has child been seen by a dentist? ❑ No ❑ Yes If so, how often?_____ Date of last visit_____

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.
Has your child had: ❑ Chickenpox ❑ Measles ❑ Mumps ❑ Rubella ❑ Meningitis ❑ Tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes
Do any household members smoke? ❑ No ❑ Yes
TV-hours per day________ Computer-hours per day________ Video games-hours per day_______

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.
____
____
____
Hospitalizations/operations (with dates): ______________________
____
Broken bones or severe sprains: ______________________

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Admin use only	Mom 1	Dad 2	Sister 3	Brother 4	Mom's Mom 5	Mom's Dad 6	Dad's Mom 7	Dad's Dad 8	Mom's Sister 12	Mom's Brother 13	Dad's Sister 14	Dad's Brother 15
Alcoholism	33												
Anemia	1												
Asthma	5												
Autoimmune Disorder	34												
Bleeding Problem	7												
Cancer, Breast	8												
Cancer, Melanoma	10												
Cancer, Ovary	11												
Congenital Anomaly/Birth Defect	36												
Heart Attack/Heart Disease	13												
Depression	14												
Diabetes, on insulin shots	37												
Diabetes, not on insulin	38												
Eczema	17												
Food Allergy	39												
Genetic Disorder	19												
Hay Fever	20												
Hearing Disorder	21												
High Cholesterol	22												
High Blood Pressure	23												
Immune Disorder	24												
Kidney Disease	25												
Mental Retardation or Learning Disability	40												
Stroke	28												
Substance Abuse	43												
Thyroid Disorders	30												
Tobacco Use	30.5												
Tuberculosis	31												
Death before age 56 for reason not listed above													
Other:													
Other:													

SOCIAL HISTORY

Who lives at home?

Name Age Relationship Highest Education Level

____

____

____

____

Are your child's parents ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced If divorced or separated, when? ______

Mother's Occupation ______________________ Mother's Employer ______________________

Father's Occupation ______________________ Father's Employer ______________________

Child care situation ☐ Parents ☐ Others (specify who and hours per day) ______________________

____

Concerns about your child: ☐ Alcohol use ☐ Tobacco ☐ Sexual activity ☐ Aggressive behavior

Is violence at home a concern? ☐ No ☐ Yes Are there guns in the home? ☐ No ☐ Yes

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐ No ☐ Yes

Current grade ________ Name of school ______________________________

Any concerns about school performance? ______________________________

Any concerns about relationship with: Teachers ☐ No ☐ Yes

Students ☐ No ☐ Yes

If more than 4 years old: does your child have a best friend? ☐ No ☐ Yes

Sports/exercise: Type ____________________ How often? ______________ How long (minutes)? ________

REVIEW OF SYMPTOMS: Please check (✓) any current problems your child has on the list below:

Constitutional

___ Fever/chills/excessive sweating

___ Unexplained weight loss/gain

Eyes

___ Squinting/"crossed" eyes/ asymmetric gaze

Ear/Nose/Throat

___ Unusually loud voice/hard of hearing

___ Mouth breathing/snoring

___ Bad breath

___ Frequently runny nose

___ Problems with teeth/gums

Cardiovascular

___ Tires easily with exertion

___ Shortness of breath

___ Fainting

Respiratory

___ Cough/wheeze

___ Chest pain

Gastrointestinal

___ Nausea/vomiting/diarrhea

___ Constipation

___ Blood in bowel movement

Genitourinary

___ Bedwetting

___ Pain with urination

___ Discharge: penis or vagina

Musculoskeletal

___ Muscle/joint pain

Skin

___ Rashes

___ Unusual moles

Allergy

___ Hay fever/itchy eyes

Neurological

___ Headaches

___ Weakness

___ Clumsiness

Psychiatric/Emotional

___ Speech problems

___ Anxiety/stress

___ Problems with sleep/nightmares

___ Depression

___ Nail biting/thumb sucking

___ Bad temper/breath holding/ jealousy

Blood/Lymph

___ Unexplained lumps

___ Easy bruising/bleeding