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LEGACY
PEDIATRICS

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____ Age _____ Male _____ Female _____

Parent's Name_____Relationship _____ Parent's Name_____Relationship_____

Form filled out by _____ Date _____

Birth History, Social History and Family History are very important aspects of pediatric care. Please complete as thoroughly as possible. If your family has a history of serious or chronic illnesses they need to be documented in your child's chart. If you have any questions about this please feel free to discuss with your provider.

Child's Past Medical History: Pregnancy/Neonatal Period (circle)

Where was your child born?_____Is the child yours by: birth   adoption   stepchild   other

Pregnancy complications _____ Delivery by: vaginal   c-section

Reason for c-section _____ Complications _____

Was your child premature? No Yes   born at _____ weeks

Complications_____ _____Birth weight _____ Length_____

Other problems in the newborn period _____ _____

Infancy/Childhood/Adolescence:

Has your child ever been treated for or diagnosed with: (explain)

o Asthma or reactive airway disease _____

o Wheezing or bronchiolitis _____

o Seasonal allergies or eczema _____

o Food allergy _____

o Recurrent ear infections _____

o Pneumonia _____

o Urinary tract infections _____

o Genetic syndrome _____

o Seizures _____

o Anemia _____

o Broken bone _____

o Mental retardation or learning disability _____

o Depression/anxiety _____

o Other chronic medical conditions _____

_____

Family History:

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐

Please explain all positives.

Has your child ever been hospitalized: No Yes (explain)

_____

Previous surgeries and dates _____

Previous pediatrician _____

Please list any specialist your child is currently seeing and reason: _____

_____

Social History

Any pets? Yes No If yes, please specify_____   Does anyone smoke in the home? Yes   No

Who lives with the child?_____