WFMA

Waynesboro Family Medical Associates, LLP

PEDIATRIC HEALTH HISTORY

(Use from birth to 10 years)

Today's Date: ____________

Child's Name: ____________ Date of Birth: ____________ Age: ______

PREGNANCY & BIRTH Where was your child born? ____________ ☐ Vaginal ☐ C-Section

Is this child yours by ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other ____________

Mecical problems during pregnancy: ☐ None ☐ Yes (specify) ____________

During pregnancy did you use ☐ Tobacco ☐ Illegal drugs ☐ Alcohol ☐ Medications (list): ____________

Birth weight ________ Birth length ________ APGAR scores 1 min. _____ / 5 min. _____

Problems during the newborn period: ☐ None ☐ Premature, how early? ________ ☐ Other (list) ____________

NUTRITION & FEEDING

Breastfed? ☐ No ☐ Yes, how long? ____________ Bottle ☐ No ☐ Yes

Has your child had any problems with eating or foods? (list) ____________

Intake now: ☐ Breast milk ☐ Formula ☐ Cow's milk (1%, 2%, whole milk) ☐ Soy milk ☐ Rice milk ☐ Juice

☐ Other (water, soda, tea) Average ounces per day (8 ounces=1 cup) ____________

☐ Baby food ☐ Table food ☐ Meats ☐ Fruits ☐ Vegetables ☐ Whole grains ☐ Sweets ☐ Junk food

SLEEP Any concerns/problems with sleep? (list) ____________

Hours per night: ________ Naps ☐ No ☐ Yes, number and length: ____________

Where does your child sleep? ☐ Bassinette ☐ Crib ☐ Own bed ☐ Parents room ☐ Own room ☐ Other ________

DEVELOPMENT At what age did your child: Smile ______ Sit alone ______ Walk alone ______ Say words ______

Toilet train ______ Ride a tricycle ______ Read words ______ (females) Have first menstrual period ______

DENTAL HISTORY Has your child been seen by a dentist? ☐ No ☐ Yes, how often? ____________

Date of last dental visit: ____________ What type of water does your child drink? ☐ City water ☐ Well water

IMMUNIZATIONS/INFECTIOUS DISEASES Did you bring your child's immunization record to their appointment?

☐ No ☐ Yes ☐ Will bring to next appointment ☐ Records with another care provider (name) ____________

Has your child had: ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Tuberculosis (TB) Hepatitis B

☐ Meningitis ☐ Pneumonia ☐ Influenza (flu)

EXPOSURE/HABITS Does the patient, or do any household members:

Use tobacco? ☐ No ☐ Yes Use illegal drugs? ☐ No ☐ Yes Drink alcohol? ☐ No ☐ Yes

Concern about lead exposure? ☐ No ☐ Yes ☐ Old home ☐ Old plumbing ☐ Peeling paint ☐ Other (list) ________

TV-hours per day ________ Computer-hours per day ________ Video game-hours per day ________

Signature of person completing this form: ____________

Reviewed by Provider: ____________

PEDIATRIC HEALTH HISTORY

Child's Name: ______________________ Today's Date: ____________

PAST MEDICAL HISTORY Previous doctor: □ None □ Yes (name)____________

Allergies/reactions to medicines or vaccines: ____________

Current Medications: (including vitamins, herbs, supplements, birth control pills)

Name	Dose	How many times per day	When started

Major Medical Problems: □ None □ Yes, (list) ____________

Hospitalizations/ Operations: □ None □ Yes, (list) ____________

Broken bones/ Severe Injuries: □ None □ Yes, (list) ____________

FAMILY HISTORY Please note family members (mother, father, sister, brother, aunt, uncle, grandparent)

Alcoholism ________ Heart attack ________ High cholesterol ________ Stroke ________

Cancer ________ High blood pressure ________ Depression/suicide ________ Diabetes ________

Sudden/early death ________ Other ________

SOCIAL HISTORY List all household members below:

Name	Age	Relationship	Name	Age	Relationship

Are the child's parents: □ Married □ Unmarried □ Separated □ Divorced □ Other ____________

If separated/divorced, when? ____________

Mother's occupation: ____________ Employer: ____________

Father's occupation: ____________ Employer: ____________

Child care situation: □ Parent(s) □ Day Care □ Other (specify) ____________

Concerns about your child: □ Alcohol use □ Tobacco use □ Drug use □ Sexual activity □ Aggressive behavior □ Violence at home

SAFETY Check all that apply.

Are there guns in the home? □ No □ Yes

Smoke detectors in home? □ No □ Yes

Uses infant seat/booster/seat belt in the car? □ No □ Yes

Wears helmet for bike/scooter/skateboard/ATV use? □ No □ Yes

SCHOOL HISTORY Does your child attend school? □ No If Yes. □ Public □ Private □ Home schooled □ Preschool

Current grade: ________ Name of school: ____________

Any problems with school grades, teachers or student relationships? □ No □ Yes, ____________

Involved in activities/sports/exercise? □ No □ Yes (list) ____________

Signature of person completing this form: ____________

Reviewed by Provider: ____________

PEDIATRIC HEALTH HISTORY

Child's Name: ______________________ Today's Date: __________

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

General
___ fevers/chills/excessive sweating
___ unexplained weight loss/gain

Eyes
___ squinting/cross eyes

Ears/Nose/Throat
___ unusually loud voice/hard of hearing
___ mouth breathing/snoring
___ bad breath
___ frequently runny nose
___ problems with teeth/gums

Heart/Cardiovascular
___ tires easily with exercise
___ shortness of breath
___ fainting

Lungs/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
___ speech problems

Psychiatric/Emotional
___ anxiety/stress
___ problems with sleep/nightmares
___ depression
___ nail biting/thumb sucking
___ bad temper/breath holding/jealousy

Blood/Lymph
___ unexplained lumps
___ easy bruising/bleeding

Signature of person completing this form: ______________________
Reviewed by Provider: ______________________