Capitol Pediatrics, P.C.
Health History Form

Today's date:_____/_____/20___

Child's Full Name:_____
Date of Birth:_____ Sex: M__F__
Parents' Full Names:_____ Age_____
_____Age_____

Is this child yours by Birth:___Adoption___Step□child:___Foster:___Other:_____
Does or will the child attend daycare? _____
Name of School: _____

Maternal and Birth History:

Gestation: Full Term_____ Premature (#weeks)_____
Was this pregnancy normal? _____ Any Complications? _____
Place of Birth:_____
Type of Delivery: Vaginal__ C□Section__
If C□section, please explain why:_____
Birth Weight:____pounds_____ounces Birth Length:_____inches
After delivery did this child:
Have to stay in the hospital longer than the mother Yes___No___
If yes, please explain _____
Have breathing difficulties Yes___No___
If yes, please explain _____
Have jaundice Yes___No___
If yes, please explain _____
Go to the NICU Yes___No___
If yes, please explain _____
Was or is the baby breast fed ___or bottle fed___ What formula _____

CHILD'S PAST MEDICAL HISTORY:

Has your child ever been treated for or had problems with the following:

Asthma or Reactive Airway Disease	Yes__No__	_____
Wheezing or Bronchiolitis/RSV	Yes__No__	_____
Seasonal Allergies or Hayfever	Yes__No__	_____
Eczema	Yes__No__	_____
Food Allergy	Yes__No__	_____
Recurrent Ear Infections	Yes__No__	_____
Pneumonia	Yes__No__	_____
Urinary Tract Infections	Yes__No__	_____
Seizures	Yes__No__	_____
Anemia (low Iron)/Bleeding Problems	Yes__No__	_____
Broken bones	Yes__No__	_____
Heart murmur or other heart problems	Yes__No__	_____
Chicken Pox	Yes__No__	_____
Attention problems/Learning Difficulties	Yes__No__	_____
Developmental Delays	Yes__No__	_____
Toilet Training	Yes__No__	_____
Behavior	Yes__No__	_____
Speech	Yes__No__	_____
Other	Yes__No__	_____

Any medication allergies? What reaction did the child have?

_____

_____

_____

Any chronic medical conditions?

_____

_____

_____

Any hospitalizations?

_____

_____

_____

Any surgeries including ear tubes, tonsillectomy, hernia repair (include dates)?

_____

_____

_____See any specialists?

(who/where)_____

FAMILY HISTORY:

Do any blood relative family members have or have had any of the following:

If yes, who?

Asthma [ ] _____

Alcoholism/Drug Abuse [ ] _____

Allergies [ ] _____

Anemia/Blood disorders [ ] _____

Crossed eyes [ ] _____

Cancer [ ] _____

High blood pressure [ ] _____

Heart disease [ ] _____
Thyroid disorder [ ] _____
Diabetes [ ] _____
Kidney disease [ ] _____
Depression/Anxiety [ ] _____
ADHD [ ] _____
Migraine Head aches [ ] _____
High Cholesterol [ ] _____
Genetic Disorders [ ] _____

SOCIAL HISTORY:

The patients' parents are:
Married [ ] Divorced [ ] Separated [ ] Unmarried but living together [ ]
Who lives in the home?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____