



## 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) \_\_\_\_\_

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**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 [ ] \_\_\_\_\_

