WESTERN WAKE WELLNESS

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WESTERN WAKE WELLNESS, PLLC
PEDIATRIC HEALTH HISTORY

Form Completed by: _____ **Patient Name:** _____

Date Completed: _____ **Birth Date:** _____ **Age:** _____ MALE or FEMALE

HOUSEHOLD - Please list all those living in the child's home

NAME	RELATIONSHIP TO CHILD	AGE	HEALTH PROBLEMS

Are there siblings not listed? If so, please list their names, ages, and where they live: _____

_____

What is the child's living situation if not with both biological parents? □ Joint Custody □ Single Custody

□ Lives with Adoptive Parents □ Lives with Foster Family

If both parents DO NOT have legal custody of the child, please provide a copy of the court papers to our office.

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

_____

BIRTH HISTORY □ Don't know birth history

Birth Weight: _____ Was the baby born at term? ___ OR ____ Weeks

Were there any prenatal or neonatal complications? □ Yes □ No

Explain: _____

Was a NICU stay required? □ Yes □ No

Explain: _____

During pregnancy, did mother take Prenatal Vitamin □ Yes □ No

Drink Alcohol □ Yes □ No Use Drugs or Medications □ Yes □ No

Explain: _____

Was the delivery □ Vaginal □ Induced Vaginal □ Cesarean

If cesarean, why? _____

_____

Did baby require resuscitation at birth? □ Yes □ No

Was initial feeding □ Breast milk □ Formula

How long was child breastfed? _____ □ Currently breastfeeding

Did your baby go home with mother from the hospital?

□ Yes □ No Explain: _____

GENERAL DK = don't know

Do you consider your child to be in good health? □ Yes □ No □ DK Explain _____

_____

Does your child have any serious illnesses or medication conditions? □ Yes □ No □ DK Explain _____

_____

Has your child had any surgery? (please include circumcision, ear tubes) □ Yes □ No □ DK Explain _____

_____

Has your child ever been hospitalized? □ Yes □ No □ DK Explain _____

_____

Is your child allergic to medication? Any life-threatening food allergies? □ Yes □ No □ DK Explain _____

_____

Is your child under the care of any other health professionals? □ Yes □ No □ DK Explain _____

_____

Are you worried about you or your child's safety at home? □ Yes □ No □ DK Explain _____

Does anyone at home smoke? □ Yes □ No

What is your child's vaccination status? □ Up to date □ Delayed or Selective □ Unvaccinated □ Undecided

(If your child is behind on immunizations, you will be asked to sign the American Academy of Pediatrics Refusal to Vaccinate form.)

BIOLOGICAL FAMILY HISTORY DK = don't know	Have any family members had the following?
Childhood Hearing or Vision loss	□ Yes □ No □ DK Who_____
Nasal allergies or Asthma	□ Yes □ No □ DK Who_____
Tuberculosis or Infectious disease	□ Yes □ No □ DK Who_____
Heart attack, Stroke or High Cholesterol	□ Yes □ No □ DK Who_____
Diabetes	□ Yes □ No □ DK Who_____
Depression, Anxiety, Suicide	□ Yes □ No □ DK Who_____
Anemia	□ Yes □ No □ DK Who_____
Bleeding disorder	□ Yes □ No □ DK Who_____
Cancer	□ Yes □ No □ DK Who_____
Drug or alcohol abuse	□ Yes □ No □ DK Who_____
Liver or Kidney disease	□ Yes □ No □ DK Who_____
Epilepsy	□ Yes □ No □ DK Who_____

PAST MEDICAL HISTORY DK = don't know	Does your child have, or has your child ever had:
Chickenpox	□ Yes □ No □ DK When_____
Pertussis, whooping cough	□ Yes □ No □ DK Explain_____
Frequent ear infections	□ Yes □ No □ DK Explain_____
Problems with ears or hearing	□ Yes □ No □ DK Explain_____
Nasal allergies	□ Yes □ No □ DK Explain_____
Problems with eyes or vision	□ Yes □ No □ DK Explain_____
Congenital cataract/retinoblastoma	□ Yes □ No □ DK Explain_____
Asthma, bronchitis, bronchiolitis, pneumonia	□ Yes □ No □ DK Explain_____
Any heart problem or heart murmur	□ Yes □ No □ DK Explain_____
Anemia or bleeding problem	□ Yes □ No □ DK Explain_____
Blood transfusion	□ Yes □ No □ DK Explain_____
HIV	□ Yes □ No □ DK Explain_____
Organ transplant	□ Yes □ No □ DK Explain_____
Malignancy, Cancer, bone marrow transplant	□ Yes □ No □ DK Explain_____
Chemotherapy	□ Yes □ No □ DK Explain_____
Frequent abdominal pain	□ Yes □ No □ DK Explain_____
Constipation requiring doctor visits	□ Yes □ No □ DK Explain_____
Bed-wetting (after 5 years old)	□ Yes □ No □ DK Explain_____
Recurrent urinary tract infections	□ Yes □ No □ DK Explain_____
Kidney disease or urologic malformations	□ Yes □ No □ DK Explain_____
Metabolic/Genetic disorders	□ Yes □ No □ DK Explain_____
Sleep problems; snoring	□ Yes □ No □ DK Explain_____
Skin problems (acne, eczema)	□ Yes □ No □ DK Explain_____
Convulsions or epilepsy	□ Yes □ No □ DK Explain_____
Obesity	□ Yes □ No □ DK Explain_____
Diabetes	□ Yes □ No □ DK Explain_____
Thyroid or other endocrine problems	□ Yes □ No □ DK Explain_____
High blood pressure	□ Yes □ No □ DK Explain_____
History of serious injury, fracture, concussion	□ Yes □ No □ DK Explain_____
Developmental delay	□ Yes □ No □ DK Explain_____
Dental decay	□ Yes □ No □ DK Explain_____
History of family violence? Guns in the home?	□ Yes □ No □ DK Explain_____
Currently sexually active	□ Yes □ No □ DK Explain_____
Sexually transmitted infection	□ Yes □ No □ DK Explain_____
Pregnancy	□ Yes □ No □ DK Explain_____
Problems with menstrual cycle (girls only)	□ Yes □ No □ DK Explain_____
Has had first period? What age?	□ Yes □ No □ DK Explain_____
Use of alcohol or drugs or tobacco	□ Yes □ No □ DK Explain_____
ADHD, anxiety, depression, mood problem	□ Yes □ No □ DK Explain_____
Problems with school? Has a 504 or IEP?	□ Yes □ No □ DK Explain_____

MEDICATIONS Please list prescription medications, over the counter, herbal or natural supplements, along with dose and frequency.

ADDITIONAL CONCERNS Please use this space to share anything else that we need to know to best care for your child.