lindenhurst PEDIATRICS

Patient Health History Form

Patients Name: _____ Date of Birth: _____ Today's Date: _____

Name of person completing this form: _____ Relationship to patient: _____

Name of child's previous pediatrician: _____

Delivery and Birth History ☐ Unknown Was your child adopted? Y / N Date of Adoption: _____

Place of birth: Name of Hospital/Home _____City and State: _____

Type of delivery: ____ Vaginal If vaginal breech/feet first? Y / N ____ Caesarean If Caesarean was it planned?: Y / N

If known, how old was the birth mother at time of delivery? _____ Was the child premature? Y / N days:____ weeks:_____

Child's birth weight: _____ birth length: _____ head circumference: _____

Were there any significant medical problems during your pregnancy? Y / N

Were there any significant complications during labor or the baby's newborn period? Y / N

If yes, to any of the above, please explain: _____

_____

Growth and Development

Have you or your prior pediatrician ever had any concerns about your child's growth or development? Y / N
(speech/language, social skills, motor skills, etc)

Please provide your child's age when they first:

Sat up without help: _____ Crawled: _____ Walked without help: _____ Spoke his/her first words: _____ Slept through the night: _____

Girls only: Age at first period: _____

Please indicate any developmental concerns or issues you would like to speak to the provider about: _____

_____

_____

Child's Medical History

Please indicate with a "Y" if your child has had any of the following conditions:

Been hospitalized overnight		Pneumonia		Eating Disorder/Anorexia or Bulimia	
Asthma/wheezing		Seizure/Epilepsy		Seasonal Allergies	
Used a nebulizer		Liver Disease/hepatitis		Learning Delay	
Surgery		Kidney Disease		Learning Disability	
Broken bones		Bladder infection		ADD	
Frequent or severe sprains		Sexual Transmitted Disease		Lead Poisoning	
Mental or behavior challenges		Skin problems		Obesity/overweight	
Seen in the Emergency Room		Hearing problems		Emotional/Behavioral Challenges	

If yes, to any of above, please describe on next page.

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Child's Medical History (continued)

Please describe: _____

_____

_____

Medications and Allergies

Please list current medications, vitamins, and supplements, even those used intermittently: _____

_____

_____

Please list allergies or reactions to medications, vaccines or foods:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Family History

For each of the following family members, please list their age (or age at death) and any illnesses including diabetes, high blood pressure, heart disease, cancer, kidney problems, lung problems, depression, allergies, and arthritis:

Child's Mother:	Dad's Mother:
Child's Father:	Dad's Father:
Mom' Mother:	Child's Siblings:
Mom's Father:	

Social History

Does your child attend school: Y / N Homeschool: Y / N Daycare: Y / N Have a FT Nanny: Y / N

Does your child attend aftercare: Y / N Does your child attend summer camp: Y / N

Do you have pets in the home: Y / N

If yes, type and number of pets:_____

Parents working outside of the home: Y / N _____

What language(s) are spoken at home: _____

Approximately how many hours a day does your child spend in front of a screen: _____

Does your child exercise/play sports: Y / N If yes, when, where and how long: _____

_____

_____

Has your child had any operations or hospitalizations? Y/N If yes, please describe:

_____

_____

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