Cascade FAMILY MEDICINE

Central Utah Clinic, PC
Your Health, Your Choice.™

Today's Date:____________

PEDIATRIC HEALTH HISTORY – AGES INFANT TO 18 YEARS

Patients Name:________________________________ Parents Name:________________________________

Age:____________________ Birth date:____________________

What is child's reason for visit?____

____

Medications currently taking

____
____
____
____

Allergies to Medications or Substances

____
____
____
____

Current Symptoms:____

____
____

Have any tests been done regarding the current Problems? (List test and results if known)

____
____

What has been tried to help the problem?

____
____

Please complete the remaining sections as appropriate if not done previously at this office.

FAMILY HISTORY

Has any member of the family or close relative had:

Yes	No		Yes	No		Yes	No	
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Asthma or Hay Fever	☐	☐	Heart Disease	☐	☐	Mental Disorder
☐	☐	Cancer	☐	☐	Hemophilia/Bleeder	☐	☐	Migraine
☐	☐	Chemical Dependency	☐	☐	High Blood Pressure	☐	☐	Tuberculosis
☐	☐	Convulsion or Epilepsy	☐	☐	High Cholesterol	☐	☐	Other__________

 CONTINUED ON OTHER SIDE

BIRTH HISTORY

Hospital________________________________Obstetrician________________________________

Type of delivery (Normal, Forceps, or C Section)__________Complications________________________________

Birth Weight____________________Birth Length____________________Discharge Weight____________________

Did baby have any problems at or immediately after birth?________________________________

List age-Cooed/Laughed_______Sat_______First Word_______Held Head Up_______Walked_______Toilet Trained_______

HEALTH HISTORY

Minor/Child's Physician________________________City/State______________Phone______________

Date of last physical examination____________________Results________________________________

	Yes	No	Explanation
Is Minor/Child under care of physician now?	☐	☐	______________________________
Receiving any medication or drugs?	☐	☐	______________________________
Has your child been hospitalized?	☐	☐	______________________________
Date/Reason/Hospital			______________________________

______________________________ ______________________________

______________________________ ______________________________

Has Minor/Child had any history of or difficulty with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Chicken Pox	☐	☐	Frequent Diarrhea	☐	☐	Pneumonia
☐	☐	Anemia	☐	☐	Constipation, Diarrhea	☐	☐	Hearing Problems	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Heart Problems	☐	☐	Sinus Problems
☐	☐	Bed Wetting	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Speech Problems
☐	☐	Birth Defects	☐	☐	Drug/Alcohol Abuse	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Bladder Problems	☐	☐	Ear Infections	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Bleeding/Excessive	☐	☐	Epilepsy	☐	☐	Measles	☐	☐	Urinary Diseases
☐	☐	Cancer	☐	☐	Fainting	☐	☐	Mononucleosis	☐	☐	Vision Problems
☐	☐	Cerebral Palsy	☐	☐	Frequent Cough	☐	☐	Mumps	☐	☐	Worms
									☐	☐	Other__________

IMMUNIZATIONS

Yes	No	Date	Yes	No	Date	Yes	No	Date
☐	☐	______DPT Series of 3 Shots	☐	☐	______Polio by Mouth Series of 3	☐	☐	______Diphtheria Tetanus
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Person completing the Pediatric Health History ____

Signature Relationship to Patient