Three Little Birds Pediatrics
Health History Form – Initial Visit

Child's Name: _____ Date of Birth: _____

Your Name: _____ Relationship to Child: _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Pregnancy complications _____

Delivery by □ vaginal □ C-section

Reason for c-section _____

Complications _____

Was your child premature? □ No □ Yes

Born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Birth length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for/diagnosed with:

- □ Asthma or reac?ve airway disease
- □ Wheezing or bronchioli?s
- □ Seasonal allergies or eczema
- □ Food allergy _____
- □ Recurrent ear infec?ons
- □ Pneumonia
- □ Urinary tract infec?on
- □ Gene?c syndrome _____
- □ Seizures
- □ Anemia
- □ Broken bone _____
- □ Developmental delay/learning disability
- □ Depression or anxiety

Other chronic medical conditions _____

_____

_____

Has your child ever been hospitalized? □ No □ Yes

_____

_____

Previous surgeries and dates _____

_____

Medications

Current medications and dose: _____

_____

_____

ALLERGIES to medication: _____

_____

_____

Vitamins/Herbal Supplements/OTC Medications:

_____

_____

Development/Nutrition

At what age did your child:

Sit alone _____ Walk alone_____

Say words _____ Toilet train _____

First period (female) _____

Was your child breastfed? □ No □ Yes, duration?___

Has your child had any feeding or dietary problems?

_____

_____

Current milk intake: Type_____ oz/day_____

Social History

Do any household members smoke? □ Yes □ No

Does your child attend daycare? □ Yes □ No

How many hours per day does your child spend:

Watching TV _____ Using computer _____

Playing video games _____

Any concerns about peer or teacher relationships?

□ Yes □ No _____

_____

Any concerns about school performance?

□ Yes □ No _____

_____

Sports/exercise/extracurricular activities:

Type _____

How often? _____

Duration _____

Family History

Do any members of your family have any of the following conditions:

	Mother	Father	Sibling	Grandparent
Asthma	□	□	□	□
Anemia	□	□	□	□
Blood Disorder	□	□	□	□
Cancer	□	□	□	□
Heart Disease	□	□	□	□
High Cholesterol	□	□	□	□
High Blood Pressure	□	□	□	□
Stroke	□	□	□	□
Diabetes	□	□	□	□
Thyroid Disease	□	□	□	□
Kidney Disease	□	□	□	□
Seizures	□	□	□	□
Migraines	□	□	□	□
Anxiety/ Depression	□	□	□	□
Alcohol/ Drug Abuse	□	□	□	□
ADHD	□	□	□	□

Please explain all positives: _____
_____
_____
_____
_____

Review of Systems *(check all that apply)*

Consistitutional

- □ Fever, chills
- □ Unexplained weight loss/gain
- □ Fa?gue

Eye

- □ Blurred vision
- □ "Crossed" eyes
- □ Itchy, red or watery eyes

Ear, Nose and Throat

- □ Loud voice, hearing concerns
- □ Mouth-breathing, snoring
- □ Ear pain
- □ Frequent runny nose

Respiratory

- □ Cough, shortness of breath
- □ Chest ?ghtness, wheeze

Cardiovascular

- □ Chest pain, palpitations
- □ Tires easily with exer?on
- □ Fain?ng

Gastrointestinal

- □ Nausea, vomi?ng, diarrhea
- □ Cons?pa?on, blood in stool
- □ Abdominal pain

Genitourinary

- □ Frequent or painful urina?on
- □ Bedwe? ng, frequent accidents
- □ Vaginal or penile discharge

Neurologic

- □ Headaches
- □ Seizures
- □ Clumsiness

Psychiatric/emotional

- □ Anxiety/stress
- □ Depression
- □ Sleep problem
- □ Anger concern

Musculoskeletal

- □ Muscle pain, weakness
- □ Joint pain or swelling
- □ Bone pain

Skin

- □ Rashes
- □ Abnormal moles, discolora?ons
- □ Hair, nail concerns