



PEDIATRIC HEALTH HISTORY FORM

1. Patient Demographics & Identification

- Patient Full Legal Name: _____
- Date of Birth (MM/DD/YYYY): ____ / ____ / ____
- Sex Assigned at Birth: Male Female Gender Identity (Optional): _____
- Form Completed By (Name & Relationship): _____
- Preferred Pharmacy(address & phone no.): _____
- Providers/Specialists seen: _____

2. Reason for Visit

- Main Concern / Reason for Today's Visit: _____

3. Allergies & Current Medications

- Medication Allergies: None Yes: (name and reaction) _____
- Food Allergies: None Yes: (name and reaction) _____
- Environmental/Latex Allergies: None Yes:(name and reaction) _____
- Current Medications (Include dosage & frequency): _____

- Vitamins, Supplements, or Home Remedies: _____

4. Birth History (Required for patients under 3 years old)

- Mother's Pregnancy Complications: None Diabetes High Blood Pressure Other: _____
- Gestational Age at Birth: ____ Weeks (Full-term Premature)
- Delivery Type: Vaginal C-Section (Reason: _____)
- Birth Weight: ____ lbs ____ oz
- Neonatal Complications: None Jaundice NICU Stay Breathing Issues Feeding Difficulties
- Newborn Feeding: Breastfed (Duration: _____) Formula

5. Developmental & Growth Milestones (For patients under 5 years old)

Please write the approximate age when your child achieved the following:

- Sat Unsupported: ____ Months
- Crawled: ____ Months
- Walked Alone: ____ Months
- Spoke First Words: ____ Months
- Daytime Toilet Trained: ____ Months
- Any Current Developmental Concerns?: No Yes: _____

CONTINUE TO BACK PAGE

6. Past Medical & Surgical History

Check all that apply to the child:

- ADD or ADHD
- Asthma / Reactive Airway
- Blood Diseases
- Congenital Heart Defects / Murmurs
- Developmental Delays /ADHD /Autism
- Eczema /Severe Rashes /Hives
- Muscle, Joint, or Bone Problems
- Skin Problems
- Hospitalizations (List dates & reasons): _____
- Past Surgeries (List dates & procedures): _____
- Allergies
- Bedwetting
- Cancer
- Constipation
- Diabetes
- Headaches /Migraines
- Seizures / Neurological Issues
- Thyroid Problems
- Anemia
- Bladder or Kidney Problems
- Chicken Pox
- Mental Health Concerns (Anxiety, Depression)
- Ear Infections (3+ per year)/hearing problems
- Heart Problems
- Vision or Eye Deficits

7. Family Medical History

Check if any biological relatives (parents, grandparents, siblings) have a history of:

- Asthma / Severe Allergies (Relative: _____)
- Early Heart Disease / Stroke under age 50 (Relative: _____)
- Diabetes (Relative: _____)
- High Blood Pressure or High Cholesterol (Relative: _____)
- Mental Health Conditions / Substance Abuse (Relative: _____)
- Genetic or Childhood Disorders (Relative: _____)
- Cancer (Relative/Type: _____)

8. Social & Environmental History

- Who lives in the primary household?: _____

- Childcare / School Status: Home Daycare Preschool K-12 (Grade: _____)
- Tobacco Smoke Exposure: No Yes (Secondhand environment)
- Primary Water Source: Municipal / City Water Well Water
- Pets in the Home: No Yes (Species: _____)

9. Signatures & Attestation

To my understanding, this represents an accurate portrayal of my child's health history. I will inform Apple-a-Day Pediatrics as changes or updates occur.

- Parent/Guardian Signature: _____
- Date: ____ / ____ / _____