nuSTART | FAMILY MEDICINE & WEIGHT LOSS

Your Health. Your Weight. Our mission.

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Pediatric Health History

Date: ______________

Name: ____ Age: ______ Birth date ____/____/____
Last First MI

Pregnancy & Birth

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: ____

Any medical problems during pregnancy? ☐ None ☐ Yes: ____

Delivery by: ☐ Vaginal birth ☐ Caesarian If caesarian, why? ____

Length of pregnancy: ____________________

Birth Weight: __________ Birth Length: __________

Any medical problems during the baby's first few days? ☐ No ☐ Yes ____

Was the first hepatitis vaccine given in the hospital? ☐ No ☐ Yes

Nutrition & Feeding

Was your child breastfed? ☐ No ☐ Yes If so, how long? _______________________

Has your child had and unusual feeding/dietary problems? ☐ No ☐ Yes _______________________________________

Milk intake now ☐ Cow milk (☐ Non-fat ☐ 1% fat ☐ 2% fat ☐ Whole milk) ☐ Soy milk ☐ Rice milk

Average ounces per day (Note: 8 ounces are in 1 cup) _________

Sleep

Hours per night _______ Naps (number and length) ______________________________

Sleep problems ☐ No ☐ Yes

Development

At what age did your child: Sit alone _______ Walk alone _______ Say words _________ Toilet train _________

Girls only: age at first menstrual period _____________

Dental History

Has your child been seen by a dentist? ☐ No ☐ Yes If so how often _______________ Date of last visit ____/____/____

Immunization/Infectious diseases: Please bring the child's shot records to your appointment

Child's Name:____ Date:____________________________

Has your child had: ☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

Exposures/Habits

Any concern about lead exposure? (Old home, plumbing/peeling paint) ☐ No ☐ Yes
____

Do any household members smoke? ☐ No ☐ Yes
T.V. Hours per day _____ Computer hours per day _____ Video game hours per day _____
How many soft drinks a day? _____
Past medical history: Please describe and major medical problems and their dates
____
____
Medications: ____

Allergies: Any allergies or reactions to any medications, foods, or immunization? ☐ No ☐ Yes (please list)
____
Hospitalizations/Operations (with dates):
____
____
____
Family History: Please check any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse
Depression/psychiatric disorder
High blood pressure
Asthma/hayfever/ eczema
Heart disease or stroke before age 60
Thyroid disease
Bleeding/clotting
Inherited/genetic disorder
Seizures
kidney disease
Birth defects

School History:

Did/does your child attend preschool? ☐ No ☐ Yes Current grade _____ Name of school _________________________

Any concerns about school performance ☐ No ☐ Yes
____

Any concerns about relationships with: Teachers ☐ No ☐ Yes
____

Students ☐ No ☐ Yes
____
Sports/Exercise: Type ______________________ How often? _____________________
Social History:
Fathers name: ____ Age: ____________
Mothers Name: ____ Age: ____________
Parents occupation: Mother ___________________________ Father __________________________________

Are the child's parents ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced If divorced, when ___________

Child care situation ☐ Parents ☐ Others (specify who and hours per day)
____

Any pets? ☐ No ☐ Yes If yes, what kind? ____

Child's Name:____

Others who live at home	Relationship	Age	Receive care here?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Concerns about your child: ☐ Alcohol use ☐ Smoking ☐ Drugs ☐ Sex ☐ Aggressive behavior ☐ Withdrawn

Is violence in the home a concern? ☐ No ☐ Yes Are there guns in the home? ☐ No ☐ Yes

Review of systems: (Please check)

1. Fever/chills/excessive sweating
2. Unexplained weight loss/gain
3. Squinting/crossed eyes/lazy eye
4. Loud voice/hard of hearing
5. Mouth breathing/ snoring
6. Bad breath
7. Frequent runny nose
8. Problems with teeth/gums
9. Nausea/vomiting/diarrhea
10. Constipation
11. Blood in bowel movement
12. Fever, chills, and sweats
13. Tires easily with exercise
14. Shortness of breath
15. Fainting
16. Asthma
17. Bedwetting
18. Pain with urination
19. Discharge: penis or vagina
20. Headaches
21. Weakness
22. Clumsiness
23. Muscle/joint pain
24. Hay fever/ itchy eyes
25. Rashes
26. Unusual moles
27. Speech problems
28. Anxiety
29.Sleeping problems
30. Depression
31. Thumb sucking/nail biting
32. Bad temper/ breath holding
33. Unexplained lumps
34. Easy bruising/bleeding
35. Broken bones

Date: Initials:	Date: Initials:	Date: Initials:	Date: Initials:
Date: Initials:	Date: Initials:	Date: Initials:	Date: Initials:

______________________________ Parent/Guardian Name (please print)

______________________________ Signature & Date