Mossio Pediatrics, PLLC

Pediatric Health History

Ages 0-12 years

Child's name: _____ (First) _____ (Middle Initial) _____ (Last)

Sex: ❑ Male ❑ Female Date of birth ____/____/____

Parent/Guardian: _____ (First) _____ (Middle Initial) _____ (Last)

Phone: _____

Birthplace

Hospital: _____

City _____ State: _____

Prenatal

Did you receive prenatal care? ❑ No ❑ Yes

What month of pregnancy did you start your prenatal care? _____

Who did you see for prenatal care? _____

Who delivered your baby? _____

Did you attend prenatal classes? ❑ No ❑ Yes

Mother's Health During Pregnancy

Please indicate any of the following that were problems for you during your pregnancy.

- ❑ Vaginal bleeding
- ❑ Weight
- ❑ Swelling of the feet or ankles
- ❑ Other: _____
- ❑ Headaches
- ❑ High blood pressure
- ❑ Gestational diabetes

Did you consume alcohol during your pregnancy? ❑ No ❑ Yes, amount _____ frequency _____

Did you smoke during your pregnancy ❑ No ❑ Yes, amount _____

Did you take any prescription or over-the-counter drugs during your pregnancy? ❑ No ❑ Yes

Did you use any illegal drugs during your pregnancy? ❑ No ❑ Yes

Labor/Delivery

Gestational age at time of delivery? _____ weeks

Was your labor induced? ❑ No ❑ Yes How long were you in labor for? _____

Type of birth: ❑ Vaginal ❑ C-section Were forceps used? ❑ No ❑ Yes

Baby's weight at birth: _____ Length: _____ Apgar (if known): _____

Any complications at birth? ❑ No ❑ Yes, explain: _____

Please indicate any of the following complications that your baby had after delivery.

- ❑ Seizure
- ❑ Congenital abnormalities
- ❑ Jaundice
- ❑ Difficulty breathing
- ❑ Infection
- ❑ Difficulty sucking
- ❑ Vomiting
- ❑ Cyanosis
- ❑ Other: _____

How long did the baby stay in the hospital after delivery? _____

Did the baby have to be in a special nursery? ❑ No ❑ Yes

Was the baby circumcised? ❑ No ❑ Yes ❑ N/A Physician: _____

Child's History

List any medical problems your child currently has and when they started:

_____

_____

If your child is being treated for any illness or medical problems by another health care provider, describe the problem and indicate who is treating your child:

_____

_____

Has your child had any surgeries/procedures or been hospitalized? ❑ No ❑ Yes, please list below:

Hospital	Reason	Date	Physician

Immunizations

	Date	Date	Date	Date
DTP				
MMR				
OPV				
HIB				

Nutrition:

Please indicate the type of feeding your child receives/received.

❑ Breast Frequency: _____ Duration: _____

❑ Bottle Frequency: _____ Amount: _____ ounces Type of formula: _____

Does your child currently take vitamins: ❑ No ❑ Yes, name and dose: _____

Is your child on solid foods: ❑ No ❑ Yes

Age when cereal started: _____ Age when vegetable started: _____

Age when juices started: _____ Age when meats started: _____

Age when fruits started: _____ Age when eggs started: _____

Please indicate any of the following that your child currently has or has had in the past.

❑ Crossed or wandering eyes
❑ Recurring ear infection
❑ Ear tubes
❑ Speech problems
❑ Hearing loss
❑ Frequent colds
❑ Genetic disorders
❑ Asthma
❑ Hay fever
❑ Pneumonia
❑ Heart murmur
❑ Anemia
❑ Chronic/frequent diarrhea
❑ Recurrent vomiting
❑ Bed wetting
❑ Scoliosis
❑ Pain in arms, legs, joints
❑ Swelling in arms, legs, joints
❑ Headaches
❑ Seizures
❑ Whooping cough
❑ Chicken pox
❑ Measles
❑ Rubella (3 day measles)
❑ Mumps
❑ Polio
❑ Kawasaki's disease
❑ Scarlet fever
❑ Colic
❑ Jaundice
❑ Rheumatic fever
❑ Other, please list: _____
_____

Does your child have any of the following allergies:

❑ No allergies _____

❑ Medications, list: _____

❑ Food, list: _____

❑ Other, list: _____

Development 0-5 years of age

Current age of your child:

How old was your child when he/she started doing the following?

Rolled over by self _____ Stood alone _____ Caught a ball _____

Sat by self _____ Walked by self _____ Talking _____

Crawled _____ Fed self _____ Toilet trained _____

If the section below does not apply to your child at this time, skip to the next section. If this section does apply to your child, please indicate the date on the line below the date that you are completing this information.

Development 6-18 years of age

Date this section is being completed: _____

Current age of your child: _____

How old was your child when he/she started school? _____ years

What grade is your child in? _____ grade

Does your child have any hearing problems? ❑ No ❑ Yes

Does your child have any vision (eye) problems? ❑ No ❑ Yes

How does your child learn best? ❑ Written materials ❑ Audio (listening) ❑ Visual (pictures)

Does your child have any learning disabilities? ❑ No ❑ Yes, explain: _____

Social History

Does your child have any kind of problems relating to his/her peers? ❑ No ❑ Yes ❑ N/A

Who does your child live with? ❑ Both parents ❑ Mother ❑ Father ❑ Other

Number of people living in your home: _____

Are your living conditions appropriate/sufficient? ❑ No ❑ Yes

Is your child's primary language English? ❑ No, list primary language: _____ ❑ Yes _____

As the parent/guardian of this child, is English your primary language? ❑ No, list: _____ ❑ Yes _____

How do you prefer information for teaching/instructions?

❑ Written materials ❑ Audio (listening) ❑ Visual (pictures) ❑ Any of those listed

Family History

Mother's name: _____ Age: _____ Occupation: _____

Father's name: _____ Age: _____ Occupation: _____

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Living arrangements of parents: ❑ Living together ❑ Living apart

Family History (continued)

Please indicate any of the following that a member of your family currently has or has had in the past.

❑ Birth defects	❑ Cancer	❑ Hay fever	❑ Thyroid problems
❑ Obesity	❑ Alcoholism	❑ Hepatitis	❑ Arthritis
❑ DES exposure	❑ Diabetes	❑ Asthma	❑ Psychiatric disorder
❑ Mental retardation	❑ Cystic fibrosis	❑ High blood pressure	❑ Sexually transmitted disease
❑ Headaches	❑ Anemia	❑ Heart disease	
❑ Allergies	❑ Epilepsy	❑ Stroke	

Safety/Housing Concerns

Do you have smoke detectors in your home? ❑ No ❑ Yes

Do you have carbon monoxide detectors in your home? ❑ No ❑ Yes

Does anyone smoke in your home? ❑ No ❑ Yes

Do you have any nutritional concerns? ❑ No ❑ Yes

Does your child drink dairy/milk? ❑ No ❑ Yes (1-3 cups daily) ❑ Yes (3-6 cups daily)

Does your child have access to unlocked cupboards containing harmful substances? ❑ No ❑ Yes

Does your child have a car/booster seat that is age appropriate? ❑ No ❑ Yes ❑ N/A

Are you concerned about any type of abuse in your home? ❑ No ❑ Yes

Do you have any pets? ❑ No ❑ Yes

What type of home do you live in? ❑ House ❑ Apartment ❑ Mobile home

Do you own or rent your current home? ❑ Own ❑ Rent

How old is your home? _____ years

Number of bedrooms: _____ Number of bathrooms: _____

Water source: ❑ Well ❑ City well ❑ Other

Heat source: ❑ Gas ❑ Oil ❑ Other

Thank you for taking the time to complete this form. The information you provide will be helpful in planning your child's health care.

Signature of person completing this form: _____

Relationship to the patient: _____ Date: ____ / ____ / ____