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Pediatric Health History Form

Name (optional)

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER: \_\_\_\_\_

PRESENT HEALTH CONCERNS: \_\_\_\_\_

MEDICINES/VITAMINS: \_\_\_\_\_

HERBS/HOME REMEDIES: \_\_\_\_\_

ALLERGIES /REACTIONS TO MEDICINES OR VACCINATIONS: \_\_\_\_\_

**PREGNANCY & BIRTH**

Is the child yours by:  birth  adoption  stepchild  other: \_\_\_\_\_  
Please indicate any medical problems during pregnancy  none  specify: \_\_\_\_\_

Delivery by  vaginal birth  caesarian If caesarian, why? \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR score 1 min \_\_\_\_\_ 5 min \_\_\_\_\_

Please indicate any medical problems during the baby's newborn period  none If premature, how early? \_\_\_\_\_  
other problems: \_\_\_\_\_

**NUTRITION & FEEDING**

Was your child breastfed?  No  Yes If so, how long? \_\_\_\_\_

Has your child had any unusual feeding/dietary problems?  No  Yes If yes, specify: \_\_\_\_\_

Milk intake now: Type  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 & length) \_\_\_\_\_

Any sleep problems? \_\_\_\_\_

**DEVELOPMENT**

At what age did your child: sit alone \_\_\_\_\_ walk alone \_\_\_\_\_ say words \_\_\_\_\_ toilet train (daytime) \_\_\_\_\_

Girls only: Age at first menstrual period \_\_\_\_\_

**DENTAL HISTORY:** Has child been seen by a dentist?  No  Yes If so, how often \_\_\_\_\_ Date of last visit \_\_\_\_\_

**IMMUNIZATIONS/INFECTIOUS DISEASES:** Please bring your child's immunization records to your appointment.

Has your child had:  chickenpox  measles  mumps  rubella  meningitis  tuberculosis (TB)

**EXPOSURES/HABITS** Any concerns about lead exposure? (old home/plumbing/peeling paint)  No  Yes

Do any household members smoke?  No  Yes

TV—hours per day \_\_\_\_\_ Computer—hours per day \_\_\_\_\_ Video games—hours per day \_\_\_\_\_

**PAST MEDICAL HISTORY:** Please describe any major medical problems and their dates

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/Operations (with dates): \_\_\_\_\_

Broken bones or severe sprains \_\_\_\_\_

**-PLEASE COMPLETE BOTH SIDES OF THIS FORM-**

**FAMILY HISTORY:** Please circle or check family history of the following (indicate who had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

**SOCIAL HISTORY:**

Birthplace \_\_\_\_\_ Current (or upcoming) grade: \_\_\_\_\_

Who lives at home?

Name	Age	Relationship	Highest Education level
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the child's parents  married  unmarried  separated  divorced If divorced, when? \_\_\_\_\_

Parents' occupations: Mother \_\_\_\_\_ Father \_\_\_\_\_

Child care situation  parents  others (specify who and hours per day) \_\_\_\_\_

Concerns about your child:  Alcohol use  Tobacco  Sexual activity  Aggressive behavior

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

**SCHOOL HISTORY**

Did/does your child attend preschool?  No  Yes Current grade \_\_\_\_\_ Name of school \_\_\_\_\_

Any concerns about school performance? \_\_\_\_\_

Any concerns about relationships with: Teachers  No  Yes \_\_\_\_\_  
Students  No  Yes \_\_\_\_\_

If over 4 years old does your child have a best friend?  No  Yes

Sports /exercise: Type \_\_\_\_\_ How often? \_\_\_\_\_ How long (minutes) \_\_\_\_\_

**REVIEW OF ORGAN SYSTEMS:** If child has more than one symptom on a line, circle the relevant one(s).

- |  |  |  |
|--|--|--|
| <p><u>Constitutional / Endocrine</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fevers/chills/excessive sweating</li> <li><input type="checkbox"/> Unexplained weight loss / gain</li> </ul> <p><u>Eyes</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Squinting/"crossed" eyes/ asymmetric gaze</li> </ul> <p><u>Ears / Nose / Throat</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Unusually loud voice/hard of hearing</li> <li><input type="checkbox"/> Mouth breathing/snoring</li> <li><input type="checkbox"/> Bad breath</li> <li><input type="checkbox"/> Frequent runny nose</li> <li><input type="checkbox"/> Problems with teeth/gums</li> </ul> <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cough/wheeze</li> </ul> | <p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nausea/vomiting/diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Blood in bowel movement</li> </ul> <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tires easily with exertion</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Fainting</li> </ul> <p><u>Genitourinary</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bedwetting</li> <li><input type="checkbox"/> Pain with urination</li> <li><input type="checkbox"/> Discharge: penis or vagina</li> </ul> <p><u>Neurological</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Clumsiness</li> </ul> <p><u>Musculo / Skeletal</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Muscle/joint pain</li> </ul> | <p><u>Allergy</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hayfever/itchy eyes</li> </ul> <p><u>Skin</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rashes</li> <li><input type="checkbox"/> Unusual moles</li> </ul> <p><u>Psychiatric / Emotional</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Speech problems</li> <li><input type="checkbox"/> Anxiety/stress</li> <li><input type="checkbox"/> Problems with sleep/nightmares</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Nail biting/thumbsucking</li> <li><input type="checkbox"/> Bad temper/breath holding/ jealousy</li> </ul> <p><u>Blood / Lymph</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Unexplained lumps</li> <li><input type="checkbox"/> Easy bruising/bleeding</li> </ul> |
|--|--|--|

**—PLEASE COMPLETE BOTH SIDES OF THIS FORM—**