

TRIANGLE COMMUNITY PHYSICIANS, P.A.
PEDIATRIC HEALTH HISTORY FORM

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Date of last Physical: _____

Reason for visit/health issues to discuss:

1. _____ 3. _____
2. _____ 4. _____

MEDICAL HISTORY		SURGICAL HISTORY	
Year	Medical problems/Illness/Hospitalization	Year	Prior Surgeries/Operations
	<input type="checkbox"/> None		<input type="checkbox"/> None
	Birth History: Birth weight: Gestational age <input type="checkbox"/> full term <input type="checkbox"/> premature Type of birth <input type="checkbox"/> Natural <input type="checkbox"/> C section Complications: <input type="checkbox"/> None <input type="checkbox"/> Yes (list)		

CURRENT MEDICATIONS including over-the-counter medicines, herbs, vitamins, birth control pills	ALLERGIES medications/foods
<input type="checkbox"/> None	<input type="checkbox"/> None
Local Pharmacy:	
Mail in pharmacy:	

CHILDHOOD ILLNESSES
Has your child had any of the following?:
<input type="checkbox"/> Chicken pox <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Cold sores

VACCINATIONS <i>Please bring a copy of the most recent vaccine record</i>
Has your child had all age appropriate vaccines?
<input type="checkbox"/> Yes <input type="checkbox"/> Not sure <input type="checkbox"/> No, specify which have not been received and reason for missing the vaccine:

OTHER PHYSICIANS/CLINICS list all other current physicians caring for you (gynecologists surgeons, specialists, etc.)	

SOCIAL HISTORY	
Living arrangements—child lives with: <input type="checkbox"/> Both biologic parents <input type="checkbox"/> One biologic parent <input type="checkbox"/> Shared custody <input type="checkbox"/> Adoptive parents <input type="checkbox"/> Other, specify:	Home Environment: Indoor Smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No Indoor Pets? <input type="checkbox"/> Yes <input type="checkbox"/> No Firearms? <input type="checkbox"/> Yes <input type="checkbox"/> No Lead paint <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Daytime care: <input type="checkbox"/> Licensed daycare <input type="checkbox"/> Family member/friend <input type="checkbox"/> Preschool <input type="checkbox"/> School	Home Electronics: Hours of TV watching per day: Hours of Computer/video games per day:
Education: School : Grade : Any behavior/learning concerns?	Sports: Types of sports played:

FAMILY HISTORY			
	Age/Age of death	Illnesses	Cause of death
Father	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Brothers	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Sisters	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Maternal Grandfather	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Maternal Grandmother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Paternal Grandfather	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Paternal Grandmother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased		