Pediatric Health History - Medical

Raphael Health Center

Patient_____ Date of Birth_____

Parent/Legal Guardian: _____

Previous healthcare provider: _____

Address/phone: _____

CHILD'S HEALTH HISTORY

□ Full term □ Premature (# weeks ___) Birth weight _____

Problems at birth or infancy □ No □ Yes- please list:_____

Health problems _____

Behavioral, mental or learning problems _____

Allergies _____Females, last menstrual period _____

Surgery or hospitalization: _____

Specialists involved with your child's care: _____

Prescribed medications and dose, Vitamins or Herbal supplements::_____

_____

SOCIAL HISTORY

Present in the home □ Mom □ Dad □ Siblings □ Grandparents □ Other _____

Any household member who smokes? □ Yes □ No

Childcare situation □ Parent □ Relatives □ Babysitter □ Daycare

Current or past physical, emotional or sexual abuse □ Yes □ No

Concerns about your child □ Alcohol use □Tobacco □ Drug use □ Sexual activity

FAMILY HEALTH HISTORY (Parent, Grandparent, Sibling)

□ Anemia
□ Arthritis
□ Asthma
□ Blood Disorder
□ Cancer
□ Diabetes
□ Headaches/Migraines
□ Heart trouble
□ High Blood pressure
□ Kidney problems
□ Mental disorder
□ Seizures
□ Stroke
□ Tuberculosis

_____ _____

Provider Signature Date