

## PEDIATRIC HEALTH HISTORY

### Child's Birth History

During pregnancy with child, did the mother:

Have high blood pressure?	Y	N
Have diabetes or sugar in urine?	Y	N
Have albumin or protein in urine?	Y	N
Have a urinary tract infection?	Y	N
Have German (3-day) measles?	Y	N
Take prescription medication?	Y	N
Smoke cigarettes?	Y	N
If YES, how many packs per day?		
Have venereal disease?	Y	N
Use drugs or alcoholic beverages?	Y	N
See doctor early in pregnancy?	Y	N
How long was the pregnancy?		
Was the child premature?	Y	N
Was more than one baby born?	Y	N
Was the delivery difficult?	Y	N
Was it a breech delivery?	Y	N
Was it a cesarean section?	Y	N
Was anything wrong with child at birth?	Y	N

If YES, what \_\_\_\_\_

What was the child's weight at birth? \_\_\_\_\_

What was the child's weight at discharge? \_\_\_\_\_

### Maternal and Family History

How many children has the mother had? \_\_\_\_\_

Which number is this child? \_\_\_\_\_

Has the mother had any premature births? \_\_\_\_\_

Mother's age now \_\_\_\_\_ Height \_\_\_\_\_

Father's age now \_\_\_\_\_ Height \_\_\_\_\_

Number of people living in child's home \_\_\_\_\_

Who spends the most time caring for the child? \_\_\_\_\_

### Family Illnesses

Please mark an "x" in the boxes where child's blood relatives have ever had any of the following illnesses.

	Father	Mother	Father's side	Mother's side	Sisters	Brothers
Allergies (food, pollen, medicine)						
Birth defects						
Blood disease (anemia, leukemia)						
Bone or joint disorders						
Cancers or malignancies						
Chronic lung disease (asthma, bronchitis)						
Diabetes						
Eye or ear disorders						
Heart trouble						
High blood pressure						
Kidney or urinary disease						
Mental retardation						
Muscle disease (weakness, poor control)						
Nerve disease (cerebral palsy, epilepsy)						
Psychiatric condition						
Rheumatic fever						
Thyroid disease						
Tuberculosis (TB)						
Venereal disease						
Other						

### Child's Health History

If the child has ever been hospitalized for any serious medical illness or operation, enter the most recent occurrences below:

<u>Hospitalizations</u>	<u>Reason</u>	<u>Date</u>
-------------------------	---------------	-------------

Child's name \_\_\_\_\_  
Last First M.I.

S.S.N. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_