

### **History Questions for First Visit**

Welcome to Growing Child Pediatrics! Thank you for trusting us with the care of your child. In order to provide our best care, we need to get to know your child, so please take the time to fully complete this form as accurately as possible. Thank you!

Your Child's Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### **Social History:**

Who lives in the house with your child? (check all that apply):

- Mother    Father    Brother/s (number\_\_\_\_)    Sister/s (number\_\_\_\_)  
 Stepmother    Stepfather    Grandmother    Grandfather    Other \_\_\_\_\_

Daily Activity (check all that apply):

- Home w/Parent    Home w/Nanny    Home schooled  
 Daycare (days/wk\_\_\_\_)    Home Daycare (# other kids\_\_\_\_ days/wk\_\_\_\_)  
 Preschool (days/wk\_\_\_\_)    School: Name:\_\_\_\_\_ Grade:\_\_\_\_\_

- Does anyone in your home smoke, even outside?    No    Yes
- Does your family have any pets?    No    Yes Type:\_\_\_\_\_
- Home water supply:    City water    Well water    Community well water

**Family History:** Please list any illnesses in the following family members:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Mother's Parents: \_\_\_\_\_

Father's Parents: \_\_\_\_\_

### **Past Medical History:**

- Is he/she allergic to any medications?    No    Yes Type:\_\_\_\_\_
- Did he/she miss or skip any vaccines?    No    Yes Type:\_\_\_\_\_
- Has your child ever had any surgery?    No    Yes Type:\_\_\_\_\_
- Has he/she ever been hospitalized?    No    Yes Why:\_\_\_\_\_
- Has he/she had any chronic medical problems?    No    Yes Type:\_\_\_\_\_
- Does he/she take medications regularly?    No    Yes Type:\_\_\_\_\_

**Birth History:** Born:    Vaginal    C-Section   Birth Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Full Term (36-42wks)    Early (<36wks; Born at \_\_\_\_\_ weeks)    Late (>42wks)

Any Complications?    No    Yes Type:\_\_\_\_\_

Did baby stay in hospital after mom went home?    No    Yes-why:\_\_\_\_\_

### **Review of Systems:**

• Has your child had any problems with or do you have concerns about any of the following?

- |                     |   |                          |  |
|---------------------|---|--------------------------|--|
| Health in General   | <input type="checkbox"/> No <input type="checkbox"/> Yes                | Stomach/Digestion        | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Skin                | <input type="checkbox"/> No <input type="checkbox"/> Yes                | Muscles/Bones            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Ears/Nose/Throat    | <input type="checkbox"/> No <input type="checkbox"/> Yes                | Neurological/Development | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Breathing           | <input type="checkbox"/> No <input type="checkbox"/> Yes                | Glands/Hormones          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart/Circulation   | <input type="checkbox"/> No <input type="checkbox"/> Yes                | Blood/Bleeding           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Any other concerns? | <input type="checkbox"/> No <input type="checkbox"/> Yes-comments:_____ |                          |  |

\_\_\_\_\_