Sun City Pediatrics, P.A.
Patient's Health History
To Be Filled Out By Parent/Primary Caretaker

Mother's name_____ Age ____y/o
Occupation _____
Father's name_____ Age ____y/o
Occupation _____

Patient's name _____
Patient's age _____
Date _____
Chart# _____

A. PREGNANCY AND BIRTH:

1. Mother's age at birth _____
2. Did mother had any illness during pregnancy? No Yes
   If yes, which ones?_____
3. Any medications other than vitamins? No Yes
   If yes, which ones?_____
4. Was the baby on time? No Yes
5. What was the birth weight? _____
6. What was the length at birth? _____
7. Did the baby have any trouble while in the hospital? (Jaundice, infections, other?) No Yes
   What kind? _____

B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups? _____
2. Date of last check-up: _____
3. Date of last dental check-up: _____
4. Has you child had <u>allergic reactions</u> to any medications, food, insect bites? No Yes
   Which ones? _____
5. Has your child had any <u>reactions to any immunizations</u>? No Yes
   Which ones? _____
6. Any hospitalizations other than for birth? No Yes
   For what? _____
7. Any serious injuries? No Yes
   What kind? _____
8. Are any medications taken regularly? No Yes
   Which ones? _____

C. FAMILY HISTORY:

1. Are the child's parents both in good health? No Yes
2. Circle any disease that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited diseases, venereal disease, cancer, AIDS, others _____
3. List age, sex, and general health of brothers and sisters:
   _____
   _____
4. Have any of your children died? No Yes
   If yes, explain: _____

D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? No Yes
2. Is it good now? No Yes
3. For the first 6 months, is/was your baby breast fed or bottle fed? _____
4. If still on formula, which one do you use? _____
5. Does he/she take vitamins? No Yes

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Any problems with teeth? No Yes
4. Frequent colds or sore throats? No Yes
5. Asthma, pneumonia, or recurrent cough? No Yes
6. Heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Any seizures or other problem with nervous system? No Yes
10. Any eczema, hives, or other skin condition? No Yes
11. Has you child ever been anemic? No Yes
12. Has your child had chickenpox? No Yes
13. List any other medical problems: _____
    _____
    _____

F. DEVELOPMENT:

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did he/she say any words by the time he/she was 1½ yrs old? No Yes
4. What grade is he/she in? _____
5. Does your child have speech problems? _____

G. SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other? Which one?_____
2. Is there a smoke alarm in each floor of your house? No Yes
3. Does your child <u>always</u> use a car seat/seat belt when riding in a car? No Yes
4. Are there any smokers in the household? No Yes
5. Does your child always wears a helmet when riding his/her bicycle? No Yes

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS ? No Yes
If you do, please present it with this form and we will make a copy for our records.

I. WHAT IS THE REASON FOR TODAY'S VISIT?

_____
_____
_____
_____

_____
PARENT'S SIGNATURE

_____
PHYSICIAN/ANP SIGNATURE