UPMC Hamot

Pediatric Health History

Name _____ **Date of Birth** _____/_____/_____ **Sex M / F**
Last First MI

Parent/Guardian _____ Parent/Guardian _____

Lives with _____

Any special spiritual or religious needs? □ yes □ no _____

Any special cultural needs? □ yes □ no _____

What language is spoken at home? _____

Any ALLERGIES to medications, x-ray dyes, foods, or other substances? □ yes □ no

_____

_____

_____

Family Medical History (including heart disease, TB, HIV, seizures, cancer, diabetes, etc.)

Mother	Birth Date	History
Father		
Grandparent		
Sibling/Other		

Birth History

□ Term □ Premature _____ weeks □ Late _____ weeks Birth Weight _____

□ Vaginal Delivery □ Cesarean section _____ Birth Weight _____

□ Complications of Pregnancy _____

_____

□ Newborn Complications
- □ Breathing Problems
- □ Seizures
- □ Jaundice

□ Injuries

□ Medications
_____
_____

□ Special care
_____
_____
_____

Was he/she discharged from the hospital at the same time as his/her mother? □ yes □ no

Family Medical History (please check)

□ Allergies	□ Constipation	□ Lead Poisoning
□ Anemia	□ Cystic Fibrosis	□ Learning Disorders
□ Asthma	□ Epilepsy (seizures)	□ Meningitis
□ Attention problems	□ Eating Disorders	□ Pain (chronic or unusual)
□ Bed Wetting	□ Ear Infections	□ Pneumonia
□ Behavior problems	□ Eye problems	□ Prematurity
□ Bleeding Disorder (other)	□ Feeding problems	□ Shot (immunization) reaction
□ Blood Disorder (other)	□ Hearing problems	□ Sickle Cell Anemia
□ Cancer	□ Heart problems	□ _____
□ Chronic Lung Disease (BPD)	□ Injuries	□ _____
□ Congenital Disorders	□ Immune Deficiency	□ _____
□ Colic	□ Kidney problems	□ _____

Surgeries

_____

_____

_____

Medications (including prescription drugs, fluoride, vitamins, and herbal products)

_____ _____ _____

_____ _____ _____

Developmental History

□ Rolled Over _____ □ Walked holding on _____
□ Sat unassisted _____ □ Walked alone _____
□ Crawled _____ □ Spoke _____
□ Pulled to stand _____ □ Potty trained _____
□ Stood alone _____ □ _____

Activities

□ Dance □ Gymnastics
□ Swimming □ Soccer
□ Baseball □ Basketball
□ Football □ Bicycling
□ _____ □ _____

Any special equipment or assisted devices? □ yes □ no _____
Any specific developmental concerns? □ yes □ no _____

Health Promotion & Safety

Are his/her immunizations up to date as far as you know? □ yes □ no □ not sure
Does he/she wear a safety belt in the car? □ yes □ no □ sometimes
Does he/she wear a bicycle helmet and/or other protective equipment? □ yes □ no □ sometimes
Are there firearms in the home? □ yes □ no If so, are they unloaded? □ yes □ no
Is the gun unlocked? □ yes □ no Is the ammunition stored separately? □ yes □ no
Does your home have a smoke detector? □ yes □ no Fire Extinguisher? □ yes □ no
Does your home have a Carbon Monoxide detector? □ yes □ no
Have you discussed any of the following with your child? (if appropriate for your child's age)
Abstinence, safe sex, condoms, HIV? □ yes □ no Puberty, menstruation etc.? □ yes □ no Drugs/alcohol/tobacco use? □ yes □ no

Parent/Guardian/Patient _____ Date _____