Pediatric Health History Yearly Update:

Patient 's name_____ Date of birth_____

Family History Changes (New Illnesses or Diagnoses)				
Relationship	Name	Living	Age	Major Medical Problems and/or Cause of Death
		Yes No		
		Yes No		
		Yes No		
Are there any religious or cultural factors we should take into account in planning your child's healthcare? *Yes No*				

Patient's Medical History		
Since your last well visit, has your child had any of the following		
Yes No Infectious Illnesses	*Yes No* Broken Bones	*Yes No* Asthma attacks
Yes No Hearing Problems	*Yes No* Vision Problems	*Yes No* Psychological Problems
Yes No Head Injury	*Yes No* Fatigue	*Yes No* Kidney or bladder infection
Yes No Seizures	*Yes No* Skin Problems	*Yes No* Muscle/Joint Problems
Has your child had any other medical conditions? (Please list) *Yes No*		
Has your child been hospitalized or had surgery? *Yes No*		
Do you have any concerns about your child's development? *Yes No*		

Childs Social Characteristics	
School Grade/Preschool:	City Water: *Yes No*
Hours of TV/Electronics Each Day:	Exposure to Second Hand Smoke: *Yes No*
Special Diet:	Guns in Home: *Yes No*
Weekly Hours of Outdoor Activity:	Wears Sunscreen: *Yes No*
Pets:	Wears Seatbelt/Car Seat/Booster: *Yes No*
Sports/Hobbies:	Special Communication Needs: *Yes No*

Allergies		
Does your child have any allergies to medications or foods and environmental allergies? (list) *Yes No*		
Medications		
Does your child take any medications, including over the counter medications, herbs, vitamins and supplements? (list and include dosage and frequency) *Yes No*		
Specialty Providers		
Has your child seen any medical providers outside of this practice, currently or in the past? (list provider and approximate date last seen) *Yes No*		

Parent Signature:_____ Date:_____