

**PRIMECARE PEDIATRICS**

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**PATIENT HEALTH HISTORY FORM**

**CHILD'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER:** \_\_\_\_\_

**PRESENT HEALTH CONCERNS:** \_\_\_\_\_

**MEDICINES/VITAMINS:** \_\_\_\_\_

**HERBS/HOME REMEDIES:** \_\_\_\_\_

**ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS:** \_\_\_\_\_

**PREGNANCY & BIRTH:**

Where was your child born? \_\_\_\_\_  
Is the child yours by:  Birth  Adoption  Stepchild  Other: \_\_\_\_\_  
Please indicate any medical problems during pregnancy  None  Specify: \_\_\_\_\_  
Delivery by  Vaginal birth  Caesarean. If Caesarean, why? \_\_\_\_\_  
Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR score: 1 min. \_\_\_\_\_ 5 min. \_\_\_\_\_  
Please indicate any medical problems during the baby's newborn period  None. If premature, how early? \_\_\_\_\_  
Other problems: \_\_\_\_\_

**NUTRITION & FEEDING**

Was your child breastfed?  No  Yes. If so, how long? \_\_\_\_\_  
Has your child had any unusual feeding/dietary problems?  No  Yes. If yes, specify: \_\_\_\_\_  
Milk intake now: Type  Cow's milk ( Non-fat  1 % fat  2% fat  Whole milk)  Soy milk  Rice milk  
Average ounces per day (Note: 8 ounces = 1 cup) \_\_\_\_\_

**SLEEP**

Hours per night \_\_\_\_\_ Naps (number & length) \_\_\_\_\_  
Any sleep problems?  No  Yes (Please specify) \_\_\_\_\_

**DEVELOPMENT**

At what age did your child: Sit alone \_\_\_\_\_ Walk alone \_\_\_\_\_ Say words \_\_\_\_\_ Toilet train (daytime) \_\_\_\_\_  
Girls only: Age at first menstrual period \_\_\_\_\_

**DENTAL HISTORY:** Has child been seen by a dentist?  No  Yes. If so, how often? \_\_\_\_\_ Date of last visit \_\_\_\_\_

**IMMUNIZATIONS/INFECTIOUS DISEASES:** Please bring your child's immunization records to your appointment.  
Has your child had:  Chickenpox  Measles  Mumps  Rubella  Meningitis  Tuberculosis (TB)

**EXPOSURES/HABITS:** Any concerns about lead exposure? (Old home/plumbing/peeling paint)  No  Yes  
Do any household members smoke?  No  Yes  
TV-hours per day \_\_\_\_\_ Computer-hours per day \_\_\_\_\_ Video games-hours per day \_\_\_\_\_

**PAST MEDICAL HISTORY:** Please describe any major medical problems and their dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/Operations (with dates): \_\_\_\_\_

Broken bones or severe sprains (with dates): \_\_\_\_\_

## FAMILY HISTORY

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's	Mom's	Dad's	Dad's	Mom's	Mom's	Dad's	Dad's
	1	2	3	4	Mom 5	Dad 6	Mom 7	Dad 8	Sister 12	Brother 13	Sister 14	Brother 15
Alcoholism												
Anemia												
Asthma												
Autoimmune Disorder												
Bleeding Problem												
Cancer, Breast												
Cancer, Melanoma												
Cancer, Ovary												
Congenital Anomaly/Birth Defect												
Heart Attack/Heart Disease												
Depression												
Diabetes, on insulin shots												
Diabetes, not on insulin												
Eczema												
Food Allergy												
Genetic Disorder												
Hay Fever												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Mental Retardation or Learning Disability												
Stroke												
Substance Abuse												
Thyroid Disorders												
Tobacco Use												
Tuberculosis												
Death before age 56 for reason not listed above												
Other: <i>(please specify)</i>												
Other: <i>(please specify)</i>												

## SOCIAL HISTORY:

Who lives at home with the child?

Name <i>(Last, First)</i>	Age	Sex		Relationship	Highest Education Level
		M	F		
		M	F		
		M	F		
		M	F		
		M	F		
		M	F		
		M	F		

Child's Parents are  Married  Unmarried  Separated  Divorced. If divorced or separated, when? \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Mother's Employer \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Father's Employer \_\_\_\_\_

Child Care situation:  Parents  Others: (please specify who and hours per day) \_\_\_\_\_

Concerns about your child:  Alcohol abuse  Tobacco  Sexual activity  Aggressive behavior  Other: (specify) \_\_\_\_\_

Is violence at home a concern?  No  Yes

Are there guns in the home?  No  Yes. If yes, how are they kept? \_\_\_\_\_

**SCHOOL HISTORY:**

Did/does your child attend school or pre-school?  No  Yes

Name of School \_\_\_\_\_ Current grade \_\_\_\_\_

Any concerns about school performance?  No  Yes. If yes, please specify \_\_\_\_\_

Any concerns about relationships with: Teachers  No  Yes If yes, please specify \_\_\_\_\_

Students  No  Yes If yes, please specify \_\_\_\_\_

If more than 4 years old, does your child have a best friend?  No  Yes

Sports/Exercise: Type \_\_\_\_\_ How often? \_\_\_\_\_ How long (minutes) \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Please indicate with a check (√) any current problems your child has on the list below:

<b>Constitutional</b>	Fevers/chills/		<b>Genitourinary</b>	Bedwetting		
	Excessive sweating			Pain/burning with urination		
	Unexplained weight loss			Discharge: Penis or Vagina		
<b>Eyes</b>	Squinting		<b>Musculoskeletal</b>	Muscle pain		
	"Crossed" eyes			Joint pain		
	Asymmetric gaze			Rash		
<b>Ears/Nose/Throat</b>	Unusually loud voice		<b>Skin</b>	Unusual moles		
	Hard of hearing			Hay fever		
	Mouth breathing/snoring			Itchy eyes		
	Bad breath		<b>Allergy</b>	Headaches		
	Frequent runny nose/congestion			Weakness		
	Problems with teeth/gum			Clumsiness		
<b>Cardiovascular</b>	Tires easily with exertion		<b>Neurological</b>	Speech problems		
	Shortness of breath			Anxiety		
	Fainting			Stress		
	Palpitations			Problems with sleep/nightmares		
<b>Respiratory</b>	Cough			<b>Psychiatric/Emotional</b>	Depression	
	Wheezing				Nail biting	
	Chest pain				Thumb/Lip sucking	
<b>Gastrointestinal</b>	Nausea/vomiting				Bad temper/jealousy	
	Diarrhea				Breath holding	
	Constipation				<b>Blood/Lymph</b>	Unexplained lumps
	Blood in stool		Easy bruising/bleeding			
<b>OTHER</b>			<b>OTHER</b>			