

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:

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