PEDIATRIC CONFIDENTIAL HEALTH AND SOCIAL HISTORY (0-10 YEARS)

Name: ______________________________ DOB: ______________

Age: ______________________ Date: ______________________

Does your child take medicine regularly? ☐ No ☐ Yes

☐ Fluoride ☐ Vitamins ☐ Aspirin ☐ Tylenol ☐ Cold Medicine ☐ Other: ______________

Is your child allergic to any medicine? ☐ No ☐ Yes If yes, what: ______________________

Does your child have other allergies? ☐ No ☐ Yes If yes, what: ______________________

Has your child been hospitalized or had surgery? ☐ No ☐ Yes When / why: ______________________

Has your child been vaccinated? ☐ No ☐ Yes

CHILD'S HEALTH PROBLEM (Check box if your child has had any of these)

☐ Eye / Vision Problem	☐ Accidents / Injury	☐ Anemia
☐ Ear / Hearing Problem	☐ Usual Bruising / Bleeding Disorder	☐ Sickle Cell
☐ Toothache / Decay	☐ High Cholesterol	☐ Diabetes
☐ Asthma / Breathing Problem	☐ Blood Transfusion	☐ Low Blood Sugar
☐ Heart Disease / Murmur	☐ Bone / Joint / Muscle Problem	☐ Kidney / Bladder Problem
☐ High Blood Pressure	☐ Headaches	☐ Seizures / Epilepsy
☐ Stomach Aches	☐ Exposure to Dangerous Chemicals	

Has your child ever been beaten, shaken, or otherwise physically hurt by someone? ☐ No ☐ Yes

Has anybody touched your child on their private areas without your or your child's permission? ☐ No ☐ Yes

☐ Problem with private ______________________

☐ Other: ______________________

Check box if your child has had any of these diseases: (Please fill in age if known)

		Age			Age
☐	Chicken Pox	______	☐	Pneumonia	______
☐	Hepatitis	______	☐	Rheumatic Fever	______
☐	Measles	______	☐	Tuberculosis	______
☐	Mononucleosis	______	☐	Whooping Cough	______
☐	Mumps	______	☐	Other: ______	______

CHILD'S DEVELOPMENT – At what age did your child: (Please fill in age if known)

	Age				Age		
Sit alone	______	☐ Not Yet	☐ Don't Know	Use Toilet	______	☐ Not Yet	☐ Don't Know
Stand Alone	______	☐ Not Yet	☐ Don't Know	Ride Tricycle	______	☐ Not Yet	☐ Don't Know
Walk Alone	______	☐ Not Yet	☐ Don't Know	Skip	______	☐ Not Yet	☐ Don't Know
Start to Speak	______	☐ Not Yet	☐ Don't Know	Read	______	☐ Not Yet	☐ Don't Know
Use Sentences	______	☐ Not Yet	☐ Don't Know				

FAMILY HISTORY
(Family = brother, sister, mother, father, grandmother, grandfather—Check box if a family member had any of these)

☐	Hepatitis	☐	Alcohol / Drug Problem	☐	Mental Illness
☐	Cancer	☐	Smoking	☐	Sickle Cell Anemia
☐	SIDS (Sudden Infant Death)	☐	Diabetes	☐	High Blood Pressure
☐	Epilepsy / Seizures	☐	Tuberculosis	☐	High Cholesterol
☐	Mental Retardation	☐	Birth Defects	☐	Heart Attack before age 50
☐	Hearing Loss	☐	Kidney Disease	☐	Stroke before age 50

CHILD'S BIRTH HISTORY (Please complete for child under 2 years old)

Birth weight:_______________pounds ____________ ounces Length ____________inches

Born at: ☐ Hospital ____________________________________ ☐ Home

Place of Birth: City __________________________________ State____________ Country __________________

Problems during pregnancy / labor / delivery: ____

____

____

MOTHER'S PREGNANCY HISTORY (Complete for children under 2 years old)

Number of pregnancies: ______ Miscarriages: ________ Abortions: _____ Number of living children: ______

Did mother receive prenatal care? ☐ No ☐ Yes

How many months pregnant was mother when prenatal care began? __________

Did mother have any problems during pregnancy / labor / delivery? ☐ No ☐ Yes ________________________________

Delivery was ☐ Vaginal ☐ Cesarean

Did mother use any drugs or medicines during pregnancy? ☐ No ☐ Yes

☐ Alcohol ☐ Street Drugs __________________________ ☐ Over the Counter Medications_________________________

☐ Tobacco ☐ Needles to shoot up Drugs_______________ ☐ Other Medicines Prescribed by Doctor___________________

☐ Caffeine ______________________________________ ____

Has mother been in a treatment program for drug /alcohol use? ☐ No ☐ Yes ___________________________________

Is your child in school? ☐ No ☐ Yes If yes, what grade? ______________Any problems? ________________________

Do you have any special problems or concerns? ____

____

____

Name of person filling out form: ____________________ Relationship to child: ______________________________

Signature: ____