NEWHOUSE
Health Solutions
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PEDIATRIC HISTORY FORM

PATIENT DEMONGRAPHICS:

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____ Fathers mobile: _____

Mother_____ DOB_____/_____/_____Father _____DOB_____/_____/_____

Pediatrician/Family MD _____City & State _____ Last Visit: ____/____/___

Who is responsible for this bill? ☐ Father Social Security # _____-_____-_____ ☐ Mother Social Security # _____-_____-_____
☐ Other *(please explain):*

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other Please explain:_____

If your child is experiencing ***Pain/Discomfort please identify where _____and for how long _____.***

1. **When did the** Problem first begin? Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? __No __Yes If yes when?
   _____
3. Any **bowel or bladder** problems since this problem began?: __ No __Yes
   (Describe):_____
4. Have you seen any **other doctors** for this problem? __ No __ Yes If yes who? _____
5. How long ago? _____Days _____ Weeks _____ Months _____Years
6. What were the results of past treatment?
   _____
7. How is this problem **NOW:** __ Rapidly Improving __ Improving Slowly __ About the Same __ Gradually Worsening __On & Off
8. Please list any **medication taken** for this problem:
   _____
9. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____

10. Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____

PAST HISTORY:

HAS YOUR CHILD EVER SUFFERED FROM: *mark a* **Y for** *YES OR N NO*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems	☐ Dizziness
☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD	☐ Fainting	☐ Arm Problems
☐ Stomach Aches	☐ Ruptures/Hernia	☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux
☐ Muscle Pain	☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____	
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Asthma	☐ Scoliosis
☐ Anemia	☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Colic
☐ Broken Bones	☐ Sleeping Problems	☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib
☐ Fall off swing	☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	☐ Other: _____	

INFANT HISTORY:

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____
Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor
List all **IMMUNIZATIONS** your child has had **:**_____
Has your child ever been treated at the emergency room? _____ if yes; please explain _____
Has your child ever been hospitalized? _____ if yes; please explain _____
Has your child ever had any Surgeries? _____ if yes; please explain _____
Is your child currently on any medication? _____ if yes; please list: _____
AT WHAT AGE DID THE CHILD: Respond to sound _____ Follow an object with his/her eyes _____
Sit alone _____ Hold heel up _____ Crawl _____ Stand _____Walk alone _____
AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:
Chicken pox _____ Mumps _____ Measles _____ Rubella _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow
Type of Birth: _____Normal vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum
Location: _____Home _____Hospital _____Birthing Center_____Other:_____
Problems during Pregnancy:
_____
Problems during Labor/Delivery:
_____
Was there presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?
*If yes, please explain*_____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High / Low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

Other facts concerning the health of any other family members which may or may not be relevant to your child's current state of health, but that you feel you would like the doctor to be aware of?
_____