Patient Health History Form

2405 York Road, Suite 103
Timonium, MD 21093
443-841-7668
443-841-7644 (fax)
contactus@padoniapeds.com
www.padoniapeds.com

PATIENT'S NAME: _____ DOB:_____ DATE:_____

Previous Physicians Name:_____Date of Last Check-up/Physical:_____

Primary Health Concerns:_____

Primary Pharmacy Information:

Name:_____Phone:_____Address:_____

MEDICATIONS

Current medications and dose:_____

_____

_____

Vitamins: _____

_____

Herbal/home remedies:_____

_____

ALLERGIES (list all and reactions)

_____

_____

_____

_____

_____

_____

PREGNANCY & BIRTH

Where was your child born?_____

Is your child: ☐ Birthed ☐ Adopted ☐ Stepchild ☐ Other

_____

Weight at birth: lbs. oz. Length: inches

Medical Problems During Pregnancy: ☐ No ☐ Yes

Please Specify:_____

Child was delivered by: ☐ Caesarean ☐ Vaginal Birth

Problems During Newborn Period: ☐ No ☐ Premature

_____

Other Problems:_____

SLEEP

Hours per night _____ Naps? ☐ No ☐ Yes Hrs/Days _____

Has your child experienced sleeping problem? ☐ No ☐ Yes

If yes, please explain _____

_____

NUTRITION & FEEDING

Was your child breastfed? ☐ No ☐ Yes, for how long_____

Has your child experienced any dietary or eating problems?

☐ No ☐ Yes

Please explain_____

_____

DEVELOPMENT

At what age did your child: Sit up _____ Speak_____

Crawl_____ Stand up_____ Walk_____

Girls only: Age at first menstrual period _____

EXPOSURES

Do members of the household smoke? ☐ No ☐ Yes

Concerns with lead exposure? ☐ No ☐ Yes

How many hours per day does your child: Watch TV_____

Play on computer_____

DENTAL

Has your child seen a dentist? ☐ No ☐ Yes

Date of last appointment/cleaning:_____

SOCIAL HISTORY

Who lives in the house with your child? ☐ Mom ☐ Dad ☐ Sibling - # ___ ☐ Grandparents ☐ Other_____

Childcare: ☐ Parents ☐ Relative _____ ☐ Daycare ☐ Babysitter/nanny ☐ Other _____

Day/Hours per week the child is not with the parents/guardian_____

School Name: _____

Concerns with performance at school? ☐ No ☐ Yes _____

Concerns with relationships with Teachers ☐ No ☐ Yes _____

Students ☐ No ☐ Yes _____

Sports/exercise: Type _____ Hours per day _____

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IMMUNIZATIONS *Please bring your child's records to your appointment.*

Has your child had the following immunizations? Check all that apply

☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ TB (Tuberculosis)

PAST MEDICAL HISTORY

Has your child ever been treated for, or diagnosed with any of the following:

☐ Anemia _____
☐ Anxiety/Depression _____
☐ Asthma_____
☐ Broken Bone
☐ Bronchitis/Wheezing _____
☐ Ear Infections_____
☐ Eczema_____
☐ Food Allergies_____
☐ Genetic Syndrome_____
☐ Learning Disabilities/Developmental Disabilities
☐ Pneumonia
☐ Seasonal Allergies
☐ Seizures
☐ Urinary Tract Infections
☐ Other chronic medical conditions:_____
_____
_____
_____

FAMILY HISTORY

Please indicate if any members of the child's family have had the following conditions, including which family member.

Conditions	Mother	Father	Grandparent	Siblings	
ADD/ADHD	☐	☐	☐	☐	_____
Alcoholism	☐	☐	☐	☐	_____
Anemia	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	_____
Depression/Suicide	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	_____
Heart Attack/Disease	☐	☐	☐	☐	_____
High Cholesterol	☐	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	☐	_____
Migraines	☐	☐	☐	☐	_____
Seizures	☐	☐	☐	☐	_____
Stroke	☐	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	☐	_____

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REVIEW OF SYSTEMS

Has the child recently experienced any of the following? Check all that apply.

Constitutional
☐ Fatigue ☐ Fever, chills
☐ Excessive thirst ☐ Unexplained weight gain/loss

Gastrointestinal
☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Blood in stool ☐ Abdominal pain

Ear Nose & Throat
☐ Hearing problems ☐ Mouth Breathing, snoring
☐ Ear pain ☐ Runny nose

Cardiovascular
☐ Chest pain ☐ Tires easily with exertion
☐ Fainting

Respiratory
☐ Cough ☐ Shortness of breath
☐ Chest tightness ☐ Wheezing

Genitourinary
☐ Frequent or painful urination ☐ Bedwetting
☐ Frequent accidents ☐ Vaginal / Penile discharge

Muscoskeletal
☐ Muscle pain ☐ Weakness ☐ Bone pain
☐ Joint pain ☐ Swelling

Neurologic
☐ Headaches ☐ Seizures
☐ Clumsiness ☐ Milestone delay

Other (eye, skin, blood
☐ Blurry vision ☐ Squinting ☐ Bruising or bleeding
☐ Cross eyed ☐ Itchy eyes ☐ Rashes ☐ Moles

Psychiatric/emotional
☐ Anxiety/Stress ☐ Depression
☐ Sleep Problems ☐ Anger issues
☐ Attention problems ☐ Impulsivity

Signature_____ **Date**_____