KIDS TIME PEDIATRICS

INITIAL PEDIATRIC HEALTH HISTORY

Your child's health is important to us. Please fill out this form as completely and as accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss with you. All information is treated confidentially.

PATIENT INFORMATION

Patient Name: ______________________________, ________________________, ________________________ ☐ Male ☐ Female
Last First Middle

Date of Birth: ______-_____-_______ Age:______ Child's Primary Pediatrician:__________________________________
Month Day Year

GENERAL INFORMATION

Reason for today's visit? ____

Does your child have any serious illness or medical condition? ☐ yes ☐ no Explain:____

Has your child had any serious accidents? ☐ yes ☐ no Explain:____

Has your child had any surgery? ☐ yes ☐ no Explain:____

Has you child ever been hospitalized? ☐ yes ☐ no Explain:____

Is your child allergic to any medicines or drugs? ☐ yes ☐ no Explain:____

Is your child currently taking any medications (either prescription or non-prescription)? ☐ yes ☐ no Explain:____

MEDICAL HISTORY

Check box ONLY if your child has or has ever had any of the following:

- ☐ Abdominal pain (frequent)
- ☐ Alcohol or drug use
- ☐ Allergies
- ☐ Anemia or a bleeding problem
- ☐ Asthma, bronchitis, bronchiolitis, or pneumonia
- ☐ Bed-wetting (after age 5)
- ☐ Blood transfusion
- ☐ Breathing difficulties
- ☐ Broken bones or sprains
- ☐ Chickenpox
- ☐ Constipation
- ☐ Cough (persistent)
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Earache
- ☐ Ear infections
- ☐ Ear or hearing problem
- ☐ Epilepsy or convulsions
- ☐ Eye or vision problems
- ☐ Headaches (frequent)
- ☐ Heart problem or murmur
- ☐ Hepatitis
- ☐ Measles, rubella, mumps
- ☐ Menstrual periods started (for girls)
- ☐ Menstrual period problems (for girls)
- ☐ Nausea / vomiting
- ☐ Nosebleeds
- ☐ Rectal Bleeding
- ☐ Rheumatic fever
- ☐ RSV
- ☐ Sinus problems
- ☐ Skin conditions (chronic) – i.e. eczema
- ☐ Sore throat, strep throat
- ☐ Stomachache (frequent)
- ☐ Thyroid or endocrine problem
- ☐ Urinary tract infection

☐ Any other significant problem ____

Guarantor Signature:____ Date:_________________