BrevardHEALTHAlliance
INCORPORATED

Pediatric Health History Form

Name: ______________________________ **Date of Birth:** __________

Do you have any concerns about your child? ☐ Yes ☐ No
Explain: ______________________________

____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No
Explain: ______________________________

____

Has your child had any surgery? ☐ Yes ☐ No
Explain: ______________________________

____

Has your child stayed overnight in the hospital? ☐ Yes ☐ No
Explain: ______________________________

____

Is your child allergic to any medications, drugs, or foods? ☐ Yes ☐ No
Explain: ______________________________

____

Please list all parents and siblings:

Name	Birthdate	Relationship

Child lives with
- ☐ Mother
- ☐ Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Grandmother
- ☐ Grandfather
- ☐ Adoptive parent(s)
- ☐ Foster parent(s)
- ☐ Other: __________

Child's Parents: ☐ Married ☐ Unmarried/living together ☐ Unmarried/not living together
☐ Separated ☐ Divorced ☐ Unknown

Does anyone in the household smoke? ☐ Yes ☐ No
Is the child exposed to anyone who smokes? ☐ Yes ☐ No

Does your child attend
Daycare? ☐ Yes ☐ No Where? ______________________________
School? ☐ Yes ☐ No Where? ____________________ Grade? ______
Does your child receive any extra services at home, daycare or school? __________

____

Do you have any concerns about your child's behavior or performance? __________

____

Birth History ☐ unknown

Birth weight: ________ Birth length: ________

Was the baby born ☐ on time ☐ ________

Was the delivery ☐ vaginal ☐ cesarean

If cesarean, why? ________

Problems during pregnancy? ________

Problems with baby after delivery? ________

Maternal use during pregnancy?

Medications: ☐ Yes ☐ No

What?

Prenatal Vitamin ☐ Yes ☐ No

Tobacco ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

Drugs ☐ Yes ☐ No

What? ________

Did baby go home with mom? ☐ Yes ☐ No Explain: ________

Feeding Type: ☐ Breastmilk ☐ Formula Name: ________

Family History

	M	F	S	MGM	MGF	PGM	PGF
Healthy							
ADHD							
Allergies							
Anemia							
Asthma							
Autism/Developmental Delay							
Heart Disease (CAD)							
Diabetes							
Drug/Alcohol Abuse							
High Blood Pressure (HTN)							
High Cholesterol/Lipids							
Migraines/Headaches							

(M = mother, F = father, S = sibling, MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather)

Explain: ________

Additional information you would like us to know: ________

Child’s last physician: ________

☐ Unknown

________ Sign

________ Date