INITIAL PEDIATRIC HEALTH ASSESSMENT

Name of Child	Today's Date	Chart#
Date of Birth	Mother Age:	Historical Source
Age Now: Sex:	Father Age:	Siblings:

BIRTH HISTORY

Hospital, City, State		Pregnancy/delivery problems?
Delivery Type		Post Partum complications?
Was baby discharged with mother? [ ] Yes [ ] No		Why not?
Birthweight lbs. oz.	Length	[ ] Breast [ ] Formula

MEDICAL HISTORY

** Allergies to food, medications, or environmental antigens?	
Hospitalizations	
Surgeries	
Injuries/ Accidents	
Significant Illnesses	

Child has had:

- ☐ Chicken Pox
- ☐ Mumps
- ☐ Measles
- ☐ TB
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Any other problems _____
- ☐ Colic / Abdominal Pain
- ☐ Seizures
- ☐ Headaches
- ☐ Pneumonia
- ☐ Bladder Infections
- ☐ Sickle Cell Disease/Trait
- ☐ Heart Murmur
- ☐ Sinus Problems
- ☐ Ear Infections
- ☐ Hay Fever
- ☐ Eczema
- ☐ Anemia

Present Medications:	Other Concerns:
Language spoken at home	Exposure to tobacco smoke ?
Primary Caretaker of child	Alcohol, other drug contacts ?

FAMILY MEDICAL HISTORY

Blood relative has had:

- ☐ Anemia
- ☐ Sickle Cell Disease/Trait
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Drug Abuse
- ☐ Alcoholism
- ☐ Other _____
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ Birth Defects
- ☐ Deafness
- ☐ Mental Retardation
- ☐ Hay Fever
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Eczema
- ☐ High Blood Pressure
- ☐ Cancer