ACCESS PLUS
Adding Quality to Your Life ™

PEDIATRIC HEALTH HISTORY

(Use from birth to 10 years)

Today's Date:____________________

Child's Name:____ Date of Birth:________________ Age:_______

PREGNANCY & BIRTH

Where was your child born?__________________________________ ☐ Vaginal ☐ C-Section

Is this child yours by ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other____

Medical problems during pregnancy: ☐ None ☐ Yes (specify) ____

During pregnancy did you use ☐ Tobacco ☐ Illegal drugs ☐ Alcohol ☐ Medications (list): _____________________________

Birth weight _________ Birth length _________ APGAR scores 1 min._____/ 5 min. _____

Problems during the newborn period: ☐ None ☐ Premature, how early? __________ ☐ Other (list) ____________________

NUTRITION & FEEDING

Breastfed? ☐ No ☐ Yes, how long? ________________ Bottle ☐ No ☐ Yes

Has your child had any problems with eating or foods? (list) ____

Intake now: ☐ Breast milk ☐ Formula ☐ Cow's milk (1%, 2%, whole milk) ☐ Soy milk ☐ Rice milk ☐ Juice

☐ Other (water, soda, tea) Average ounces per day (8 ounces= 1 cup) ______________________

☐ Baby food ☐ Table food ☐ Meats ☐ Fruits ☐ Vegetables ☐ Whole grains ☐ Sweets ☐ Junk food

SLEEP

Any concerns/problems with sleep? (list) ____

Hours per night: ____________ Naps: ☐ No ☐ Yes, number and length: ____

Where does your child sleep? ☐ Bassinette ☐ Crib ☐ Own bed ☐ Parents room ☐ Own room ☐ Other ________________

DEVELOPMENT

At what age did your child: Smile ________ Sit alone________ Walk alone ________ Say words _________

Toilet train ________ Ride a tricycle ________ Read words ________ (females) Have first menstrual period ________

DENTAL HISTORY

Has your child been seen by a dentist? ☐ No ☐ Yes, how often? ___________________________

Date of last dental visit: ________________ What type of water does your child drink?: ☐ City water ☐ Well water

IMMUNIZATIONS/INFECTIOUS DISEASES

Did you bring your child's immunization record to their appointment?

☐ No ☐ Yes ☐ Will bring to next appointment ☐ Records with another care provider (name) _________________________

Has your child had : ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Tuberculosis (TB) ☐ Hepatitis B

☐ Meningitis ☐ Pneumonia ☐ Influenza (flu)

EXPOSURE/HABITS

Does the patient, or do any household members:

Use tobacco? ☐ No ☐ Yes Use illegal drugs? ☐ No ☐ Yes Drink alcohol? ☐ No ☐ Yes

Concern about lead exposure? ☐ No ☐Yes ☐ Old home ☐ Old plumbing ☐ Peeling paint ☐ Other (list) ________________

TV-hours per day _______________ Computer-hours per day ______________ Video game-hours per day _______________

Signature of person completing this form: ____

Reviewed by Provider: ____

PEDIATRIC HEALTH HISTORY

Child's Name: ______________________ Today's Date: ______________

PAST MEDICAL HISTORY Previous doctor: ☐ None ☐ Yes (name) ______________________

Allergies/reactions to medicines or vaccines: ______________________

Current Medications: (including vitamins, herbs, supplements, birth control pills)

Name	Dose	How many times per day	When started

Major Medical Problems: ☐ None ☐ Yes, (list) ______________________

Hospitalizations/ Operations: ☐ None ☐ Yes, (list) ______________________

Broken bones/Severe Injuries: ☐ None ☐ Yes, (list) ______________________

FAMILY HISTORY Please note family members (mother, father, sister, brother, aunt, uncle, grandparent

Alcoholism ________ Heart attack ________ High cholesterol ________ Stroke ________

Cancer ________ High blood pressure ________ Depression/suicide ________ Diabetes ________

Sudden/early death ____________ Other ____________

SOCIAL HISTORY List all household members below:

Name	Age	Relationship	Name	Age	Relationship

Are the child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Other ______________

If separated/divorced, when? ______________

Mother's occupation: ______________ Employer: ______________

Father's occupation: ______________ Employer: ______________

Child care situation: ☐ Parent(s) ☐ Day Care ☐ Other (specify) ______________

Concerns about your child: ☐ Alcohol use ☐ Tobacco use ☐ Drug use ☐ Sexual activity ☐ Aggressive behavior ☐ Violence at home

SAFETY Check all that apply.

Are there guns in the home? ☐ No ☐ Yes Uses infant seat/booster/seat belt in the car? ☐ No ☐ Yes

Smoke detectors in home? ☐ No ☐ Yes Wears helmet for bike/scooter/skateboard/ATV use? ☐ No ☐ Yes

SCHOOL HISTORY Does your child attend school? ☐ No If Yes, ☐ Public ☐ Private ☐ Home schooled ☐ Preschool

Current grade: ____________ Name of school: ______________________

Any problems with school grades, teachers or student relationships? ☐ No ☐ Yes, ______________

Involved in activities/sports/exercise? ☐ No ☐ Yes (list) ______________

Signature of person completing this form: ______________________

Reviewed by Provider: ______________________

PEDIATRIC HEALTH HISTORY

Child's Name: ______________________________ Today's Date: ______________

REVIEW OF SYSTEMS Please check (√) any current problems your child has on the list below:

General
___ fevers/chills/excessive sweating
___ unexplained weight loss/gain

Eyes
___ squinting/cross eyes

Ears/Nose/Throat
___ unusually loud voice/hard of hearing
___ mouth breathing/snoring
___ bad breath
___ frequently runny nose
___ problems with teeth/gums

Heart/Cardiovascular
___ tires easily with exercise
___ shortness of breath
___ fainting

Lungs/Respiratory
___cough/wheeze
___ chest pain

Gastrointestinal
___ nausea/vomiting/diarrhea
___ constipation
___ blood in bowel movement

Genitourinary
___ bedwetting
___ pain with urination
___discharge: penis or vagina

Musculoskeletal
___ muscle/joint pain

Skin
___ rashes
___ unusual moles

Allergy
___ hay fever/itchy eyes

Neurological
___ headaches
___ weakness
___ clumsiness
___ speech problems

Psychiatric/Emotional
___ anxiety/stress
___ problems with sleep/nightmares
___ depression
___ nail biting/thumb sucking
___ bad temper/breath holding/jealousy

Blood/Lymph
___ unexplained lumps
___ easy bruising/bleeding

Signature of person completing this form: ______________________________
Reviewed by Provider: ______________________________