IHA Pediatrics History Form

for office staff: Prov____MA____

Patient Name: _____ Date of Birth: _____

Parent/GuardianName:_____Occupation_____
Parent/GuardianName:_____Occupation_____
Siblings & dates of birth:_____

Patient lives with: _____

Significant Past Medical Problems, illnesses or hospitalizations: _____

_____

_____

Past Surgery _____ Year_____

_____ Year_____

_____Year_____

Active or Chronic Problems (check all that apply for this patient or list below):

☐ ADD/ADHD	☐ DDH – hip dysplasia	☐ Diabetes	☐ Autism	☐ Seizures
☐ Allergies	☐ Deafness	☐ Ear Infections (frequent)	☐ Mental Illness	☐ Strabismus (lazy eye)
☐ Asthma	☐ Depression/Anxiety	☐ Eczema	☐ Migraines/Headaches	☐ Sickle Cell
☐ Cancer	☐ Developmental Delay	☐ Elevated Cholesterol	☐ Heart Disease	☐ Scoliosis
☐ Other (list below)				☐ Frequent or Recurrent UTI

Please explain any that apply:

_____

Please list other pertinent information we should know, including other doctors and/or specialists your child sees:

_____

_____

Patient's Drug Allergies & reaction: _____

Patient's Food Allergies & reaction: _____

Current Medications – Please list all over the counter medications, supplements, herbal medications and/or any medications prescribed by your previous doctor or specialist.

Medication	Dosage	Times per Day	Prescribed by

OVER PLEASE

Patient Name: _____ Date of Birth: _____

Social History

Parent's Relationship __Married __Living Together____Never together___Separated__Divorced
__Single Parent__Guardian/Foster___Father not involved__Mother not involved

Child Care: ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling ☐ Nanny ☐ Daycare ☐ Sitter ☐ Other: _____

Home Safety: (Please check a box for each category)

Smokers in home
☐ Yes ☐ No

Carbon monoxide detector
☐ Yes ☐ No

Smoke detector
☐ Yes ☐ No

Uses bike/skating helmet
☐ Yes ☐ No

Firearms in home
☐ Yes ☐ No

Radon in home
☐ Yes ☐ No
☐ Unknown

Seatbelt/car restraint
☐ Face rear
☐ Booster
☐ Face front
☐ Seatbelt

Pets/animals in home
☐ Birds/Chickens
☐ Cats
☐ Dogs
☐ Ferrets
☐ Guinea pigs
☐ Hamsters/Gerbils
☐ Reptiles
☐ Rabbits

Lead exposure
☐ Lead in home
☐ No lead in home
☐ Lead removed
☐ Lead status unknown

Family History: (Biological family please) ☐ Patient Adopted

	Mother	Father	Sibling	Sibling	MGM	MGF	PGM	PGF
Name (First)								
Alive/deceased (A or D)								
ADD/ADHD								
Allergies								
Asthma								
Anxiety								
Autism								
Cancer-type								
Deafness								
Depression								
Development/Learning Problems								
Diabetes								
Elevated cholesterol								
Eczema								
Heart Disease								
High Blood Pressure								
Mental Illness-type								
Migraines								
Obesity								
Seizures/Epilepsy								
Sickle Cell								
Substance Abuse-type								
Sudden death<55yr								
Thyroid								
Other- specify								