Tri-City Health Center
Pediatrics Initial Health History Questionnaire

TRI-CITY HealthCenter
Our Community. Your Health.

Today's Date: _____ Chart Number: _____
(For Office Use Only)

Patient's Name: _____ ☐Male ☐Female
Last Name, First Name

Date of Birth: _____

Mother's Name: _____ Father's Name: _____

If the parent is not the guardian, please indicate the guardian below:
Guardian's Name: _____
Please check the relationship to patient: ☐Guardian ☐Aunt / Uncle
☐ Brother / Sister ☐Foster Parent
☐ Other (please specify): _____

COMPLETE THIS SECTION IF YOUR CHILD IS LESS THAN 3 YEARS OLD

Delivery: ☐Vagina ☐C-Section
Complications (Please describe): _____
Did the baby come on time? ☐Yes ☐No
Weeks Gestation _____ Birth Weight _____ Hours in Labor _____
Neonatal Problems ____ Jaundice ____ Cyanosis ____ Apnea ____ Genetic Disease _____
Maternal Problems during Pregnancy
___ Pre-eclampsia/toxema ___ Diabetes ___ Rubella ___Anemia ___ STD
___ Surgery ___ Other: _____

Habits during Pregnancy: ☐Smoking ☐Alcohol ☐Drugs
Place of Birth: _____
Number of Days in Hospital: _____

Infant Feeding:
History: ___ Breast ____ Bottle (Age when weaned) _____ months
Current: ___ Breast times per day ____ Bottle Type of Milk or Formula

Child Diet:
Fruit Juice ___ Cereal ___ Green Vegetables ___ Protein ___ Yellow Vegetables ____
Milk(type) ____ Fast Foods ___ Vitamin/Mineral Supplement ____

Development:
At what age did infant/child did first: Smile ___ Lift Head ___ Roll Over ___
Sit Alone ___ Crawl ____ Stand ____ Walk ____
Say Words ____

PICA Does your child eat dirt, rocks, plaster, ashes, ice, etc.? ☐No ☐Yes
Has constipation ever been a problem? ☐ No ☐Yes Diarrhea? ☐No ☐Yes

DENTAL Last dental visit:
Month _____ Year _____ Never _____

WIC Referred ☐No ☐Yes Date: _____ Enrolled: ☐No ☐Yes Date: _____

IMMUNIZATIONS / HEALTH CARE
Where did child receive infant immunizations? _____
Is immunization record available? ☐No ☐Yes
Where did your child receive previous health care? _____

MEDICAL HISTORY

Has the child has any surgeries? ☐No ☐Yes
Has the child stayed overnight in a hospital? ☐No ☐Yes (describe): _____

GIRLS OVER 10 YEARS OLD:
Has she had her first menstrual period? ☐No ☐Yes

CHECK ANY OF THE FOLLOWING THAT CHILD HAS HAD:

☐ more than 3 ear infections per years
☐ more than 6 colds or throat infections per year
☐ indigestions / bad stomach aches
☐ blood in urine / pain
☐ asthma / shortness of breath
☐ hearing / ear problems
☐ seeing / eye problems
☐ teeth problems
☐ bone pain / swollen joints / limping
☐ broken bones / serious injuries
☐ eczema
☐ others (specify) _____

☐ rubella (3 day measles)
☐ measles (10 days)
☐ mumps
☐ chicken pox
☐ whooping cough
☐ pneumonia
☐ sickle cell anemia or trait
☐ hepatitis
☐ tuberculosis
☐ heart disease
☐ allergic reaction to medicine
☐ allergic reaction to vaccine

Has the child had problems in school? ☐No ☐Yes (describe): _____
_____
Is the child in special education? ☐No ☐Yes (describe): _____
_____
Is the child on any medications or drugs? ☐No ☐Yes (describe): _____
_____

FAMILY / SOCIAL HISTORY:

Check any of the following that family has had, and specify the family member
(Ex: Child's Mother, Father, Brother, Sister, Grandparents)

- ☐ allergy or hay fever _____
- ☐ anemia / low blood _____
- ☐ asthma _____
- ☐ birth defects _____
- ☐ cancer _____
- ☐ diabetes _____
- ☐ heart disease _____
- ☐ hemophilia _____
- ☐ high blood pressure _____
- ☐ kidney disease _____
- ☐ mental retardation _____
- ☐ rheumatic fever _____
- ☐ seizures / epilepsy _____
- ☐ sickle cell anemia _____
- ☐ syphilis _____
- ☐ tuberculosis _____

With whom does child live with? Check one:
☐Mother and Father ☐Mother ☐Father ☐Legal guardian ☐Other(specify): _____

Is child's mother still living? ☐Yes ☐No, cause of death _____
Is child's father still living? ☐Yes ☐No, cause of death _____

Number and age of siblings:
Sisters_____ Ages _____ Brother _____ Ages_____
All sibling's still alive? ☐Yes ☐No, cause of death _____

How many people live at home? _____

SAFETY

IS there peeling paint in the home? ☐Yes ☐No
Does your child sit in a car seat or use seat belt (appropriate for age)? ☐Yes ☐No
Do you have the number of poison control? ☐Yes ☐No