Grace Health

Pediatric History

Child's Name _____ Date of Birth _____ Date _____

Child's Birth History

❑ Full term ❑ Premature (how many weeks?) _____

❑ Vaginal delivery ❑ C-section (why?) _____

❑ Vacuum assisted ❑ Forceps assisted

Birth weight _____ Birth length _____

Any problems with pregnancy, labor or delivery? (please list) _____

_____

How many days was the baby in the hospital? _____

Any medical problems in the nursery? (oxygen, antibiotics, jaundice, etc.) _____

_____

Surgeries/Operations

Type	When	Where
_____	_____	_____

Hospitalizations

Type	When	Where
_____	_____	_____

Medications *(If you don't know the name, please indicate why the child takes the medication)*

_____

Allergies

To medications _____

Other (foods, etc.) _____

Immunizations *(Please have your child's immunization card available for our review)*

Are the child's immunizations (shots) up to date? .....❑ Yes ❑ No

If no, when was the child's last set of shots? _____

Were the shots given in the state of Michigan? .....❑ Yes ❑ No

Has the child had chicken pox? .....❑ Yes ❑ No

or received the chicken pox shot? .....❑ Yes ❑ No

Has the child completed the series of three Hepatitis B shots? .....❑ Yes ❑ No

Social History

Who lives with the child? _____

Any pets? ❑ Yes ❑ No If yes, what types? _____

Does anyone smoke? (include smoking outside the house) ❑ Yes ❑ No

Does the child attend daycare? ❑ Yes ❑ No

If yes, please check type of daycare:

❑ in home daycare ❑ a relative's home ❑ large childcare center

Are there any guns in the home? ❑ Yes ❑ No

What grade is the child in? _____ What school? _____

Child's Health History *(Please check if the child has ever had these problems and explain)*

Skin (e.g. eczema, hives, rashes)	❑ Yes	❑ No
Head (e.g. headaches, migraines)	❑ Yes	❑ No
Eye (e.g. wears glasses)	❑ Yes	❑ No
Ears (e.g. frequent infections)	❑ Yes	❑ No
Dental (e.g. baby bottle tooth decay)	❑ Yes	❑ No
Thyroid or gland	❑ Yes	❑ No
Heart (e.g. murmur, high blood pressure)	❑ Yes	❑ No
Lung (e.g. asthma, chronic cough, cystic fibrosis)	❑ Yes	❑ No
Stomach/bowel (e.g. constipation, chronic diarrhea)	❑ Yes	❑ No
Urinary (e.g. bedwetting, daytime wetting, UTI)	❑ Yes	❑ No
Blood (e.g. abnormal bleeding or clotting, sickle cell)	❑ Yes	❑ No
Muscle (e.g. weakness)	❑ Yes	❑ No
Bone or joint (e.g. broken bones, arthritis)	❑ Yes	❑ No
Nervous system (e.g. seizures)	❑ Yes	❑ No
Behavior/mental health (e.g. ADHD, depression)	❑ Yes	❑ No
Abuse (e.g. physical, emotional, sexual)	❑ Yes	❑ No

If you answered "yes" to any of the above questions, please explain below:

_____

_____

_____

_____

Family History *(Does a family member have any of these medical problems?)*

Asthma (chronic cough)	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
Diabetes	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
Heart Disease	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
High Cholesterol	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
Cancer	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
List type of cancer _____					
High Blood Pressure	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
Mental Health	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
List type _____					
Abuse	❑ Mother	❑ Father	❑ Brother	❑ Sister	❑ Grandparent
List type (e.g. physical, emotional, sexual) _____					

Other (please explain) _____

_____

_____

_____

_____

_____