



Aspen Family Medicine

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Pediatric Health History

Welcome to our practice! Please complete the following to the best of your ability. All information is confidential and will remain as part of your child's medical record.

Date of Visit: _____
Your Name: _____
Child's Name: _____
Allergies: _____

Relationship to child _____
Gender: M F
Medications/dose: _____

Vital Information

Date of Birth _____
Birthplace (city/state) & Hospital _____
Mother's Name: _____ Occupation: _____
Father's Name: _____ Occupation: _____
DOB _____ Ethnicity _____
Ht _____ Wt _____
DOB _____ Ethnicity _____
HT _____ Wt _____
Are parents? Married Partnered/living together Separated Divorced Single
Who does child live with? Both parents Mom Dad Guardian _____ Siblings _____
Please list other members of the household: _____
Where does child live? House Apartment Duplex Year Built _____
Does child have own room? Yes No If no, whom does he/she share room with? _____
Any Pets? _____
Has a parent, brother or sister dies? Yes No if yes, who and what was the cause of death and age? _____
Was child adopted? Yes No If yes, at what age? _____ Country of origin? _____
Religious preference, if any _____

Pregnancy

Numbers of pregnancies before this one _____ How many weeks did the pregnancy last? _____
At how many months was prenatal care started? _____
Where any of the following present during the pregnancy?
 Measles Seizures Excessive weight gain Accident/Injury High Blood Pressure
 Depression Swelling Bleeding Gestational diabetes STD Urinary tract infection
 Other: _____
Explain: _____
Medicines or drugs used during pregnancy _____

OVER



Smoking during pregnancy? Yes No How much? _____ Which trimester? 1st 2nd 3rd or entire pregnancy
 Alcohol during pregnancy? Yes No How much? _____ Which trimester? 1st 2nd 3rd or entire pregnancy

Labor and Delivery

Was labor: Spontaneous Induced If induced, what was the reason? _____
 Was the delivery? Vaginal Cesarean section If C-Section, what was the reason? _____
 What was your Group B strep status? Positive Negative If positive, were antibiotics given during labor? Yes No
 During delivery, did any of the following occur? Use of forceps or vacuum Need for Oxygen Resuscitation
 Did baby require? Special Nursery Blood Transfusion Bili lights Antibiotics _____
 Did baby go home with you? Yes No If no, why? _____
 Was Hepatitis B vaccine given in nursery? Yes No

Birth Data

Height _____ Weight _____ Apgar Score (If known) _____ Weight at discharge _____
 Newborn Metabolic Screening Normal Abnormal (specify) _____ was 2nd metabolic screening done? Y N
 Newborn Hearing Screening Not screened Abnormal If abnormal, has follow up been scheduled? Yes No

Developmental History

At what age did your child?

Sit alone _____ Walk alone _____ Feed self _____ Talk (2-3 word sentences) _____
 Dress self _____ Toilet trained: Day _____ Night: _____

School-age child: Current Grade _____ Days missed this year _____ Reason _____
School problems: Reading/writing Behavior Special needs Other: _____

Are there any behavior problems at home? _____ if yes, please describe: _____

Infant Nutrition

Was baby breastfed? Yes No If yes, until what age? _____
 ~If no, what was the reason? _____
 ~If no, what formula was given? _____
 Problems: Vomiting Colic Diarrhea Allergies Other _____
 When was baby started on solid foods? _____ Does child have any allergies or intolerances? _____

Medical History

Does your child have any diagnosed illnesses or conditions? Yes No If yes, please list below along with date diagnosed and how treated

| Year | Reason/Surgery/Condition | Hospital, City and State |
|-------|--------------------------|--------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

NEXT PAGE



Has your child ever had the following?

| | | | | | | | | |
|----------------------------------------------|-------------------------------------------|------------------------------------------|----------------------------------|------------------------------|-----------------------------|-------------------------------------|------------------------------|-----------------------------|
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Strep Throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergies/hayfever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Whooping cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear Infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding tendency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How did it occur? _____ | | | | | |
| | | | Was there loss of consciousness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | Concussion? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | Fracture? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, which bone(s)? _____ | | |
| Blood transfusion? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reason? _____ | | | Date(s) _____ | | |
| If yes, mark box and provide date performed: | <input type="checkbox"/> TB Skin Test | <input type="checkbox"/> Lead Level Test | | | | <input type="checkbox"/> Urine Test | | |
| | <input type="checkbox"/> Hemoglobin _____ | | | | | | | |

Family History

| | Age(s) | Diseases (If deceased, cause of death) |
|----------|--------|----------------------------------------|
| Father | _____ | _____ |
| Mother | _____ | _____ |
| Siblings | _____ | _____ |

Is there a family history of any of the following:

| | | | | | |
|---------------------------------------------|---------------------------------------------------------------|-----------------------------------------------|----------------------------------------------|----------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Behavioral problems | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Bone/joint disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Clotting problems/excessive bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Gastrointestinal problems | |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Muscular weakness or illness | <input type="checkbox"/> Neurologic disorders | <input type="checkbox"/> Obesity | <input type="checkbox"/> Sudden deaths | |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Vision loss/color blindness | | | | |

Explain (please specify what kind and how related to child): _____

Review of Symptoms Please indicate if your child has had any of the following symptoms recently (leave blank if it does not apply):

Constitutional Symptoms

| | | |
|----------------------------|------------------------------|-----------------------------|
| Good general health lately | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive weight gain/loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever/night sweats | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Acting abnormal | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleeping problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | | |
|-----------------------------|------------------------------|-----------------------------|
| Sore throat or voice change | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mouth sores | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swollen glands in neck | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Cardiovascular

| | | |
|---------------------------------|------------------------------|-----------------------------|
| Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Palpitations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| shortness of breath w/ exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling feet/hands/ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | | |
|-----------------------|------------------------------|-----------------------------|
| Eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eye disease or injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eye discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Ears/Nose/Mouth/Throat

| | | |
|-------------------------|------------------------------|-----------------------------|
| Hearing loss or ringing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Earaches or drainage | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic sinus problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nose bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tooth problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stiffness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Respiratory

| | | |
|-----------------------------|------------------------------|-----------------------------|
| Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequently chokes when eats | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wheezing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive sputum production | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

OVER



Aspen Family Medicine

Gastrointestinal

- Decreased food intake Yes No
- Frequent stomachaches Yes No
- Nausea or vomiting Yes No
- Diarrhea Yes No
- Hard or painful stools Yes No
- Constipation Yes No
- Rectal bleeding Yes No
- Blood in stool Yes No

Genitourinary

- Frequent urination Yes No
- Burning/painful urination Yes No
- Red, Brown, or bloody urine Yes No
- Change in force of stream when urinating Yes No
- Frequent Bedwetting Yes No
- Kidney stones Yes No
- Potty trained Yes No
- Frequent accidents Yes No
 - Boys ~ testicle pain Yes No
 - ~ swollen/red testicle Yes No
 - Girls ~ vaginal discharge Yes No
 - ~ period started? Yes No

Musculoskeletal

- Joint Pain Yes No
- Joint stiffness/swelling Yes No
- Weakness of muscles/joints Yes No
- Muscle pain or cramps Yes No
- Back pain Yes No
- Cold extremities Yes No
- Difficulty walking/crawling Yes No

Integumentary (Skin, breast)

- Rash or itching Yes No
- Change in skin color Yes No
- Acne Yes No
- Diaper rash Yes No
- Breast lump Yes No
- Breast discharge Yes No
- Breast pain Yes No

Psychiatric

- Behavioral problems Yes No
- Learning disabilities Yes No

- Nervousness Yes No
- Depression Yes No
- Insomnia Yes No

Endocrine

- Hormone/gland problem Yes No
- Excessive thirst or urination Yes No
- Heat or cold intolerance Yes No
- Signs of sexual development Yes No
- Growth problems Yes No

Hematologic/Lymphatic

- Enlarged Glands Yes No
- 2 or more ear infections/year Yes No
- Bleeding/bruising tendency Yes No
- Anemia Yes No
- Past transfusion Yes No
- More than 6 colds a year Yes No

Allergic/Immunologic

History of skin reaction or other adverse reaction to:

- Penicillin Yes No
- Other Antibiotics Yes No
- Morphine, Demerol, or other Narcotics Yes No
- Novocain/Anesthesia Yes No
- Aspirin or other pain meds Yes No
- Tetanus antitoxin Yes No
- Iodine Yes No
- IV Contrast Yes No
- Other drugs/medications Yes No

Known food allergies _____

Known environmental allergies: _____

- Neurological Yes No
- Frequent/Recurring headaches Yes No
- Lightheaded or dizzy Yes No
- Convulsions or seizures Yes No
- Numbness or tingling Yes No
- Tremors Yes No
- Paralysis Yes No
- Head injury Yes No
- Crossed eyes Yes No

Up to date on immunizations Yes No

Age of last immunizations _____

To the best of my knowledge, the question on this form have been accurately answered. I understand that providing incorrect information can be dangerous to myself or my child's health. It is my responsibility to inform the doctor's office of any changes in my or my child's medical status. I also authorize the healthcare staff to perform necessary services that myself or my child may need.

Signature of Parent or Guardian

Date