University Physicians
University of Missouri Health Care

Woodrail General Internal Medicine/Pediatrics

Name_____ Date_____
Date of Birth_____ Place of Birth_____
Parent/Guardian 1: _____
Parent/Guardian 2: _____
E-mail Address_____
Preferred Method of Communication_____

Pediatric Health History for NEW Patients

Main reason for today's visit: _____

Where was your child receiving care before? _____

PREGNANCY & BIRTH: Please fill in the following information about your child's pregnancy and birth history as you remember.

PREGNANCY HISTORY:

Prenatal Care: [ ] Yes [ ] No Provider: _____
Blood Type: _____ Hepatitis B: + or –
How many times pregnant? ___
How many children? ___
Miscarriage/Abortion? ___
Maternal Health Problems:

[ ] Pre-eclampsia	[ ] Bleeding
[ ] Pre-Term Labor	[ ] High Blood Pressure
[ ] Infections	[ ] Diabetes
[ ] Abnormal U/S	[ ] Rh Incompatibility
[ ] Alcohol/Drugs	[ ] Tobacco/Smoking

BIRTH HISTORY:

Birth Location: [ ] Hospital [ ] Home [ ] Other
Hospital Name: _____
Due date: _____ Birth was [ ] Vaginal [ ] C-Section
Gestation: [ ] Term (37+ wks) [ ] Pre-Term (36 wks or less)
Birth Weight: _____ Birth Length: _____
Birth Head Circumference: _____
Circumcision? Y or N Hepatitis B vaccine? Y or N
Birth Problems:

[ ] Breach	[ ] Forceps
[ ] Nuchal Cord	[ ] Low APGARs
[ ] Jaundice	[ ] Breathing Problems
[ ] Shoulder Dystocia	[ ] Bleeding/Bruising
[ ] Infection	[ ] Urine/Stool Problems
[ ] Birth defects	[ ] Feeding Problems

IMMUNIZATIONS: Please list all immunizations received since birth. **Please supply shot record if available.**

Vaccine ↓ Age→	**Birth**	**2 months**	**4 months**	**6 months**	**12 months**	**15 months**	**18 months**	**4-6 years**	**11-12 years**	**13-18 years**
Hepatitis B	☐	☐		☐						
Rotavirus		☐	☐	☐						
DTaP		☐	☐	☐		☐		☐		
HIB		☐	☐	☐	☐					
Pneumococcal		☐	☐	☐		☐				
IPV		☐	☐	☐				☐		
MMR					☐			☐		
Varicella					☐			☐		
Hepatitis A					☐		☐			
Meningococcal									☐	☐
Tdap									☐	☐

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know that you wrote there.

☐ **MY CHILD TAKES NO MEDICATIONS** **Please List Your PHARMACY of Choice _____**

MEDICATION	DOSE (mg/pill)	HOW MANY TIMES PER DAY?

ALLERGIES: Please list all allergies or intolerance to medications. Please include type of reaction:

☐ **NO KNOWN ALLERGIES**

ALLERGIES:	TYPE OF REACTION:

REVIEW OF SYMPTOMS: Please mark the box for any **persistent** symptoms your child has had in the **past few weeks**. Read through every section and check "no problems" if none of the symptoms apply to your child. List other concerns above.

General:
__Fever/ chills
__Night sweats
__Unexplained weakness
__Excessive fatigue
__Decreased activity
__Unexplained weight loss/ gain
__***No Problems***

Eye:
__Eye Mattering/Discharge
__Blindness
__Blurred/Double Vision
__Glasses/Contact Lenses
__***No Problems***

Ear/Nose/Throat:
__Nose Bleeds
__Nasal Congestion
__Sore Throat/Hoarseness
__Trouble Swallowing
__Hearing loss
__Ear pain
__Dental cavities
__***No Problems***

Respiratory:
__Shortness of Breath
__Cough
__Wheezing
__Loud Snoring
__Short of breath – exercise
__***No Problems***

Cardiovascular:
__Chest Pain/Discomfort
__Heart Palpitations
__Swelling in legs/feet
__***No Problems***

Gastrointestinal:
__Nausea/Vomiting
__Diarrhea
__Blood in Stools
__Constipation
__Abdominal Pain
__Heartburn/Reflux
__Indigestion
__Bloating
__Loss of bowel control
__Problems eating
__Loss of appetite
__Excessive gas
__Rectal Pain
__***No Problems***

Genitourinary:
__Urinating More Often
__ Wetting the bed at night
__***No Problems***

Musculoskeletal:
__Back Pain
__Neck Pain
__Muscle Aches/Cramps
__Joint Pain
__Muscle Weakness
__Decreased Joint Motion
__Joint Stiffness
__***No Problems***

Hematologic/Lymphatic:
__Bruise Easily
__Bleeding Tendency
__Swollen glands
__***No Problems***

Skin:
__Rash
__Itching
__New Change in mole
__Hair Loss/Change
__Change in nails
__***No Problems***

Neurological:
__Headache
__Memory loss/confusion
__Fainting
__Dizziness
__Numbness/Tingling
__Unsteady Gait
__Frequent Falls
__Tremors
__Seizures
__***No Problems***

Psychiatric:
__Anxiety/Stress/Irritability
__Sleep Problems
__Lack of Concentration
__Change in Behavior
__Change in Personality
__Anorexia
__Binging/Purging
__***No Problems***

Endocrine:
__Heat Sensitivity
__Cold Sensitivity
__Excessive Thirst
__Excessive Hunger
__High/Low blood sugar
__***No Problems***

PERSONAL MEDICAL/SURGICAL HISTORY: Does your child have now (current) or had in the past any of the following conditions?

√	CONDITION	COMMENTS	√	CONDITION	COMMENTS
	Alcohol/Drug Abuse			Hernia Repair	
	Allergy/Hay Fever			High Blood Pressure	
	Anemia			High Cholesterol	
	Anxiety			Inflammatory Bowel Disease	
	Arthritis (Juvenile, Psoriatic, Other)			Irritable Bowel Syndrome	
	Appendectomy (appendix removal)			Kidney Disease/Failure	
	Asthma			Kidney Stones	
	Bipolar Disorder			Liver Disease	
	Blood Transfusion			Lupus	
	Cancer Leukemia			Migraine/Tension Headaches	
	Cancer (Other type)_____			Pneumonia	
	Colonoscopy/Sigmoidoscopy			Seizures/Epilepsy	
	Depression			Skin Condition (Eczema/Psoriasis)	
	Diabetes (Adult Onset) (Type 2)			Sleep Apnea	
	Diabetes (Childhood Onset) (Type 1)			Overactive Thyroid/Hyperthyroidism	
	EGD (Stomach Endoscopy)			Low Thyroid/Hypothyroidism	
	Fractures (broken bones)_____			UTI	
	Heartburn/Reflux (GERD)			Other (list)	
	Heart Condition			Other (list)	
	Heart Surgery			Other (list)	
	Hepatitis – Type A/Type B/Type C			Other (list)	

FAMILY HISTORY: Please indicate which relative has had the following diseases (Parents and siblings are the most important)

ADOPTED? YES or NO (please circle) If yes and you do **not** know your child's family history, you may skip this section.

√	DISEASE	RELATIONSHIP (Father, Mother, Children, Grandparents, Aunt/Uncles, Other)	COMMENTS
	No significant history known		
	Alcoholism/Drug abuse		
	Alzheimer's Dementia		
	Asthma		
	Autoimmune Disease		
	Bleeding or Clotting Disorder		
	Cancer _____		
	Cancer _____		
	Coronary Artery Disease (Heart Attack, Angina)		Age of Onset_____
	Depression/Suicide/Anxiety		
	Diabetes – Type 1 (childhood onset)		
	Diabetes – Type 2 (adult onset)		
	Emphysema (COPD)		
	Genetic Disorder (explain)		
	Heart Failure (CHF)		
	Hepatitis (A, B, or C)		
	High Blood Pressure (Hypertension)		
	High Cholesterol		
	Hypothyroidism/Thyroid Disease		
	Kidney Disease		
	Migraine Headaches		
	Osteoporosis		
	Stroke		
	Other (please list)		

SOCIAL HISTORY:

HOME ENVIRONMENT:

Who lives at home with your child? _____
_____
Siblings? _____
Problems or Stress at home? _____
_____

ACTIVITY:

Estimated hours of physical activity or active playtime your child engages in each week: _____
Estimated hours of TV, video games, or computer time your child engages in each week: _____
Sports or School activities? _____
Family activities? _____

GROWTH/DEVELOPMENT:

Do you think your child is growing & developing normally?
[ ] Yes [ ] No _____
Do you have any concerns about your child's growth? _____
_____
Do you have any concerns about your child's development?
_____
_____
_____

DIET:

For infants: [ ] Breast feeding [ ] Formula _____
Balanced Diet? [ ] Yes [ ] No _____
Food Allergies? [ ] Yes [ ] No _____
Special Diet? [ ] Yes [ ] No _____
Do you have any concerns about your child's nutrition? ____
_____
_____

EDUCATION:

Grade in School: ____ School Name: _____
Teacher's Name: _____
Does your child do well in school? [ ] Yes [ ] No
Does your child enjoy school? [ ] Yes [ ] No
Is your child concerned about bullying? [ ] Yes [ ] No
Is your child concerned about safety? [ ] Yes [ ] No

SAFETY:

Type of car seat: [ ] Rear-facing [ ] Forward facing
Do you use car seats or seatbelts consistently? [ ] Yes [ ] No
Do you have your child use a bike helmet? [ ] Yes [ ] No
Home has a working smoke detector? [ ] Yes [ ] No
Is violence at home a concern for you? [ ] Yes [ ] No

HEALTH MAINTENANCE SCREENING TESTS:

[ ] Newborn Screening
[ ] Lead Screening
[ ] Anemia (Hgb/Hct) Screening
[ ] Cholesterol Screening
[ ] Autism Screening (18 mths of age)
[ ] Dentist. Last visit: _____
[ ] Eye doctor. Last visit: _____

TOBACCO/ALCOHOL/DRUG EXPOSURE:

Is your child exposed to any of the following at home, school, or other locations?
Tobacco: [ ] Yes [ ] No
Alcohol: [ ] Yes [ ] No
Drugs: [ ] Yes [ ] No
Are prescription medications kept locked and away from your child at home? [ ] Yes [ ] No

Thank you for taking the time to fill out this important health documentation.