

Andover Pediatrics, P.C. Health History Form

Today's Date _____

Date of Birth _____

Child's Name _____

_____ Male _____ Female

Child's Address _____

Place of Birth _____

Hospital _____

Previous Doctor _____

Parent/Guardian Name(s)

Tel #

Occupation

1. _____

2. _____

3. _____

4. _____

Who lives at home with this child? _____

Does he or she have frequent visits elsewhere? _____

Environment

Pets Y N Smoking in Home Y N

Firearms in Home Y N

Family Health

Have any blood relatives had any of the following illnesses? If so, indicate (mother, grandparent, etc) to the child.

Asthma Y N Birth Defects Y N

Diabetes Y N Tuberculosis Y N

Epilepsy Y N Sudden Cardiac Death Y N

Mental Illness Y N Mental Retardation Y N

Cancer Y N High Blood Pressure Y N

Thyroid Disease Y N Rheumatoid Arthritis Y N

Blood Disease Y N Allergies Y N

Birth History

Were there any problems during the pregnancy with this child? YES NO

Did your child experience any problems as a newborn? YES NO

Birth weight: _____ Full-term Pre-term How many weeks _____

Growth and Development

Any concerns about your child's:

Development YES NO Physical Growth YES NO

Speech YES NO School Performance YES NO

Behavior YES NO

General Health History

Medications – Please list all medications your child is now taking including those you buy without a doctor's prescription.

Allergies and sensitivities

List anything that your child has reacted to; such as certain foods, medications, immunizations, dust, chemicals, bee stings, etc. and indicate how each affects him/her.

Allergic to Effect Allergic to Effect

Hospitalizations, Surgeries and Injuries – please list all times, if any, that your child has been seriously ill, injured, hospitalized/or operated on.

Year Operative/Illness/Injury Hospital and City
