



PEDIATRIC HEALTH ASSESSMENT

Patient's Name: _____ Date of Birth: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Parents Marital Status: Married _____ Single _____ Widowed _____ Divorced _____
Living Together _____ Separated _____

Parental involvement in child care: Father Yes / No Mother Yes / No

What language do you or your child best understand _____

Who lives in the household _____

Family Physician or Pediatrician: _____

How do you or your child best learn:

- a. One on One Instruction _____
- b. Audio Visual Information _____
- c. Written Information _____
- d. Group Instruction _____
- e. Demonstration/Practice _____
- f. Other _____

Is your child exposed to anyone who uses tobacco? Yes / No Who? _____

Does anyone in the household consume alcohol? Yes / No

Does anyone in the household use any other substances Yes / No If yes, type _____

Is your child afraid of anyone? Yes / No

Has your child ever been physically or emotionally hurt by anyone: Yes / No

Are there pets in the household? Yes / No Type: _____

Water type? City / Well

School District _____

School Concerns: Yes / No

Does your child wear a bike helmet? Yes / No

Does your child use a car seat, booster seat, or seat belt? Yes / No

Do you or your child have any special needs we should be aware of so that we can better serve you?

Updated				
Reviewed By				

OVER



PEDIATRIC HEALTH ASSESSMENT

Previous Surgery	Complications	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Current Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have allergies? Yes / No If yes, please list:

Medications: _____

Environmental: _____

Immunizations up to date Yes No

Has the patient ever had or experienced any of the following:

<p>General</p> <p>Weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight gain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eyes</p> <p>Glasses/Contact <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ENT</p> <p>Hearing problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiovascular</p> <p>Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory</p> <p>Asthma/wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bronchitis/Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Home oxygen therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cystic Fibrosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>GI</p> <p>Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Reflux <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood in stool <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Musculoskeletal</p> <p>Scoliosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Integumentary</p> <p>Rashes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Neurologic</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hydrocephalus <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Developmental Delay <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cerebral Palsy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness arms/legs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unsteady gait <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty speaking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>GU</p> <p>Painful voiding/urinating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bed wetting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urinary tract infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Toilet trained <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hematologic/Lymphatic</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Endocrine</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Immunologic</p> <p>HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ImGeneral</p> <p>Weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight gain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eyes</p> <p>Glasses/Contact <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Family Medical History:</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anesthesia Complications <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Childhood Deaths <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood/Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Name of Person Completing Form _____	Date _____	Time _____
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Relationship to Patient _____

Signature of person who reviewed and discussed above with the provider. _____	Date _____	Time _____
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