Physicians' Clinic of Iowa, P.C.

PEDIATRICS HEALTH HISTORY FORM

Patient's Name ______________________ Today's Date: ______________

Date of Birth ______________

How much did your child weigh at birth? ______________ Was your baby premature? ☐ Yes ☐ No How many weeks early? ________

Where was your child born? ☐ Mercy Medical Center (Cedar Rapids) ☐ St. Luke's Hospital ☐ Other

Did mom have any problems during pregnancy? ☐ Yes ☐ No How was baby born? ☐ Vaginally ☐ C-Section ☐ Vacuum Extraction ☐ Forceps

Were there any problems during the delivery? ☐ Yes ☐ No

Did the baby need any special help after the delivery? ☐ No ☐ Oxygen ☐ Antibiotics ☐ Lights for Jaundice ☐ Other

If other, please list: ______________________

Has your child been in the hospital overnight since he/she was born? ☐ Yes ☐ No

If yes, when and what for? ______________________

Has your child had any surgeries? ☐ Yes ☐ No

If yes, when and what for? ______________________

Does your child have any ongoing medical problems (asthma, recurrent ear infections, diabetes)? ☐ Yes ☐ No

If yes, please list and age: ______________________

Are there any other doctors who help take care of your child (allergist or ear, nose & throat doctor)? ☐ Yes ☐ No

If yes, please list: ______________________

MEDICATIONS: List all medications your child takes. Please include over-the-counter and any vitamins/supplements; list dosages and frequency.

Name of Medication (☐ See attached list for additional medications)	Dose	Frequency

ALLERGIES: Please list any allergies your child has.

Drug	Describe Reaction	Other *(seasonal, food, etc.)*	Describe Reaction

Does your child have sensitivity to Latex? ☐ Yes ☐ No Describe Reaction: ______________________

Has your child received immunizations? ☐ Yes, up to date ☐ No, none ☐ Has received some, but not all

Who does your child live with? ______________________

Parents are: ☐ Married ☐ Single ☐ Separated ☐ Divorced

If parents are not together, what is the custody arrangement? ______________________

Please list siblings:

Name	Age	Male/ Female?	Full	Half	Step	Adoptive

Please continue to the back side ⟶

What type of home does your child live in? ☐ House ☐ Apartment ☐ Condo ☐ Mobile Home ☐ Shelter

Does anyone smoke? ☐ Yes ☐ No If so, who? ____________________

Was your home built before 1960? ☐ Yes ☐ No If yes, have you done any remodeling to cover or remove old lead paint? ☐ Yes ☐ No

Does your home have: ☐ Smoke Detectors ☐ Carbon Monoxide Detectors ☐ Guns Are guns locked/secured? ☐ Yes ☐ No

☐ Pool/Hot Tub/Nearby Lake, Pond or Stream

Do you have pets in your home? ☐ Dog ☐ Cat ☐ Gerbil ☐ Hamster ☐ Bird ☐ Other____________________

Parents' Occupations: Mother: ____________________ Father: ____________________

Does your child go to daycare? ☐ Yes ☐ No Name of Provider: ____________________

If yes, daycare provider is: ☐ Relative ☐ Before/After School Program ☐ Nanny/Sitter in Your Home ☐ Licensed Daycare Center

☐ Private Home, Licensed ☐ Private Home, Unlicensed

Does your child go to school? ☐ Yes ☐ No If so, grade: __________ Name of School: ____________________

Are there potential stress issues in your home?

☐ None ☐ Alcoholism in Family ☐Chronic Illness in Family ☐ Disability in Family ☐ Drug Use in Family ☐ Domestic Violence in Family

☐ Financial Difficulties in Family ☐ Marital Difficulties ☐ Mental Illness in Family ☐ Recent Death in Family ☐ Unsafe Neighborhood

FAMILY HISTORY: Has any member of your family (father/mother/siblings/grandparents) ever had the following conditions. If yes, indicate family member.

	Condition	Family Member
☐ Yes ☐ No	ADHD	________
☐ Yes ☐ No	Allergies	________
☐ Yes ☐ No	Anxiety	________
☐ Yes ☐ No	Arthritis	________
☐ Yes ☐ No	Asthma	________
☐ Yes ☐ No	Cancer (include type)	________
☐ Yes ☐ No	Depression	________
☐ Yes ☐ No	Diabetes Mellitus	________
☐ Yes ☐ No	Heart Disease	________
☐ Yes ☐ No	High Cholesterol/Lipids	________
☐ Yes ☐ No	High Blood Pressure	________
☐ Yes ☐ No	Kidney Disease	________
☐ Yes ☐ No	Liver Disease/Hepatitis	________
☐ Yes ☐ No	Lung Disease (COPD)	________
☐ Yes ☐ No	Stroke	________
☐ Yes ☐ No	Stomach/Intestinal Problems	________
☐ Yes ☐ No	Thyroid Issues	________
☐ Yes ☐ No	Ulcers	________
☐ Yes ☐ No	Other	________

☐ Unable to obtain family history due to adoption or other circumstances.