Hawai'i Island Community Health Center

Hawai'i Island Community Health Center
Initial Pediatric Health History

P. 1	Name:	DOB:	Date:

Previous health care provider: _____ Last seen: ____/__/____ Last physical exam: ____/__/____

Specialist names within last year (Include mental health)_____ Last seen: ___/__/____

Are you being seen to follow up from recent ER or hospital visit? Yes / No If yes, where and when? _____

PREFERRED PHARMACY: **SECONDARY PHARMACY:** _____

MEDICATIONS TAKEN REGULARLY *(including over-the-counter and herbal)* **CIRCLE NO IF NONE: NO**

Medication Name	*Dose*	*How often taken*

ALLERGIES *(including medication, food and other allergens)* **CIRCLE NO IF NONE: NO**

List Medication Allergies	*Describe Reaction to Medication*	*List Food/Other Allergies*	*Describe Reaction*
1.		1.	
2.		2.	
3.		3.	

BIRTH HISTORY:

			Complete the following questions for children under 2 years old:					
Full term pregnancy	Yes	No						
Delivery gestational age		wks	Multiple birth	Yes	No	Newborn hearing test abnormal	Yes	No
Normal vaginal birth	Yes	No	Admission to NICU	Yes	No	Newborn remained after mother was discharged	Yes	No
C-section Primary or Repeat C-sxn?	Yes	No	Difficulty feeding infant	Yes	No	Recently taking IV antibiotics	Yes	No
Delivered in hospital?	Yes	No	Neonatal Jaundice	Yes	No	Newborn Metabolic Screen	Yes	No
Delivered at home?	Yes	No	Phototherapy	Yes	No	Rh Incompatibility	Yes	No
Birth weight in (pounds, ounces)			Oxygen needed after birth	Yes	No	ABO Incompatibility	Yes	No
			Pulmonary symptoms	Yes	No	Other:		

PAST MEDICAL HISTORY:

Allergies	Yes	No	Adenoidectomy	Yes	No	Headaches	Yes	No
Cancer	Yes	No	Visual Impairment	Yes	No	Febrile Seizure(s)	Yes	No
Murmur	Yes	No	Genetic History	Yes	No	Epilepsy	Yes	No
Congenital Heart Disease	Yes	No	GERD	Yes	No	Developmental Disorder	Yes	No
High Cholesterol	Yes	No	Constipation	Yes	No	Obesity	Yes	No
Fainting/Syncope	Yes	No	Anemia	Yes	No	Orthopedic/Fractures	Yes	No
Hypertension	Yes	No	Bleeding Disorder	Yes	No	ADD/ADHD	Yes	No
Eczema	Yes	No	Blood Transfusion	Yes	No	Depression	Yes	No
Diabetes Type 1	Yes	No	Sickle Cell Trait	Yes	No	Self-Mutilation/Cutting	Yes	No
Diabetes Type 2	Yes	No	Hepatitis	Yes	No	UTI	Yes	No
Thyroid disorder	Yes	No	HIV	Yes	No	Asthma	Yes	No
Recurrent Otitis Media	Yes	No	Varicella	Yes	No	Bronchitis	Yes	No
Sinusitis	Yes	No	Venereal Disease	Yes	No	Myringotomy	Yes	No
Hearing Loss	Yes	No	MRSA	Yes	No	Pneumonia	Yes	No
Tonsillectomy	Yes	No	Tuberculosis	Yes	No	Urologic Disorder	Yes	No
Other:								

p. 2	Name:	DOB:

MENSTRUAL HISTORY:

Has menstruation started?	Yes	No	Bleeding usually lasts _____ days		
Age at first period _____ yrs			Menstrual-type cramping?	Yes	No
Regular cycle intervals?	Yes	No	Severe menstual pain?	Yes	No
Menses abnormal frequency?	Yes	No	Date of last menstruation _____		

LIST PREVIOUS HOSPITALIZATIONS: *(WITH LOCATION AND DATES)* **CIRCLE NO IF NONE: NO**

LIST PREVIOUS SURGERIES: (WITH LOCATION AND DATES) **CIRCLE NO IF NONE: NO**

FAMILY MEDICAL HISTORY

(Please circle yes or no)	Mother		Father		Sister(s)		Brother(s)		Grandparents	
	Living	Deceased	Living	Deceased	Living	Deceased	Living	Deceased	Living	Deceased
Cancer	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
High Cholesterol	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Hypertension	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
ADD/ADHD	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Allergies	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Asthma	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Bleeding/Clotting Disorders	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Cystic Fibrosis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Depression	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Early Deaths	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Genetic Disease	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Headache	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Hepatitis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
HIV Infection	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Kidney Disease	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Psychiatric	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Seizure Disorder	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Sickle Cell Abnormality	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Stroke	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Thyroid Disorder	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

SOCIAL HISTORY: *(please circle answers that apply)*

Who does patient live with?	Both parents Mother Father Step-parent Grandparent Other Relative Foster Care
Are there pets in the home?	None If yes, please circle: Dog Cat Bird Fish Reptile Other:_____
Daycare/Education?	Home Babysitter Daycare Preschool School/Grade? ____ College GED Home School
Travel ouside of country?	Yes or No If yes, please list where:
Smoking status?	None Current smoker Exposure to secondhand smoke? Yes or No
Other – please circle	Caffeine use Alcohol use Drug use Exercise Habits Sports Contraception
Cultural/ethnic background	List:
Languages spoken?	List: