California Pediatrics
Come grow with us

Health History

Patient Name			DOB			
Birth History	Birth weight?	lbs	oz			
	Gestational Age (How many weeks were your pregnant)?	Weeks				
	Delivery?	Vaginal	Cesarean	Reason?		
	Pregnancy Problems?	No	Yes			
	Newborn Problems?	No	Yes			
	Newborn Nutrition?	Breast	Formula			
Medical History	Complications with early childhood?	No	Yes			
	History of asthma?	No	Yes			
	History of pneumonia?	No	Yes			
	History of recurrent ear infections?	No	Yes			
	Does your child take medications/supplements/herbs?	No	Yes			
	History of surgery?	No	Yes			
	Has your child ever seen a specialist?	No	Yes			
Developmental History	Concerns about your child's growth?	No	Yes			
	Concerns about child's development?	No	Yes			
	Concerns about your child's vision/hearing/speech?	No	Yes			
	Concerns about your child's school performance?	No	Yes	NA		
	Concerns about your child's behavior?	No	Yes			
	Concerns about your child's relationship with peers?	No	Yes			
Nutrition/Sleep	Eat 3 meals/day?	No	Yes			
	Eat fruit/vegetables daily?	No	Yes			
	Eat protein(beans, meat, chicken) daily?	No	Yes			
	Drinks milk/calcium daily?	No	Yes			
	Concerns about your child's sleep?	No	Yes			
Family History	Asthma?	No	Yes			
	High blood pressure?	No	Yes			
	Diabetes?	No	Yes			
Social History	Who does your child live with?	Mom	Dad	Both	Other	
	Are mom and dad...	Married	Divorced	Separated		
	Number of siblings?					
	Where does your child spend most of their day?	Home	School	Daycare	Other	
Safety						
	Does your child use a carseat/booster (if under 8 years old)/seatbelt?	No	Yes			
	Does your child wear a helmet?	No	Yes			
	Smokers at home?	No	Yes			
	Pets?	No	Yes			
TB Risk						
	Has your child been outside of the U.S. in the last 6 months?	No	Yes			
	Do you know anyone with a positive TB skin test?	No	Yes			
Lead Risk	Does your child live in or visit a house built before 1978?	No	Yes			