COMMUNITY HEALTH ALLIANCE

PEDIATRIC HEALTH HISTORY 0-11yr

Patient Name:	DOB:	Date:
Main reason for today's visit:		
Where were you getting your MEDICAL care before? (Previous doctor/PCP):		
Where were you getting your DENTAL care before? (Dentist):		
In the past 2 weeks, have you been bothered by:	Little interest or pleasure in doing things? ☐ Yes ☐ No Feeling down, depressed or hopeless? ☐ Yes ☐ No	

Review of symptoms: *Please mark the box (✓) and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.*

General	**Respiratory**	**Gastrointestinal**	**Psychiatric**
__ Unexplained weight loss/gain __ Unexplained fatigue/weakness __ Fever, chills __ **No problems**	__ Altered breathing during sleep __ Cough/wheeze __ Loud snoring __ **No problems**	__ Heartburn/reflux/indigestion __ Blood or change in bowel movement __ Constipation __ **No problems**	__ Anxiety/stress/irritability __ Sleep problems __ Lack of concentration __ **No problems**
Skin	**Hematologic/Lymphatic**	**Eyes**	**Allergy/Immune**
__ New or change in a mole __ Rash/itching __ **No problems**	__ Swollen glands __ Easy bruising __**No problems**	__ Change in Vision __ Eye pain/redness __ **No problems**	__ Hay fever/allergies __ Frequent infections __ Lowered immune system __ **No problems**
Neurological	**Genitourinary**	**Ears/Nose/Throat**	**Women only**
__ Headache __ Fainting/dizziness __ Numbness/tingling __ Unsteady gait __ **No problems**	__ Nighttime urination or increase frequency __ Discharge; penis or vagina __ **No problems**	__ Nosebleed __ Frequent sore throat __ Hearing loss __ Ringing in ears __ **No problems**	__ Pre-menstrual symptoms (bloating, cramps, irritability) __ Problem with menstrual periods __ **No problems**
Cardiovascular	**Musculoskeletal**	**Endocrine**	**Breast**
__ Chest pain/discomfort __ Palpitations(fast or irregular heart beat) __ **No problems**	__ Neck pain __ Back pain __ Muscle/joint pain __ **No problems**	__ Heat or cold sensitivity __ **No problems**	__ Breast lump/pain __ Nipple discharge __ **No problems**

Please list(or show us your own printed record) all prescription and non-prescription medications, vitamins, home remedies, birth control pill, herbs, inhalers, etc. use back of this form if you need more room.

☐ **TAKE NO MEDICATIONS** ☐ History of Blood thinning medications ☐ Current/Past Chemo Therapy
☐ History of steroid therapy ☐ History of aspirin therapy ☐ History of Osteoporosis medication

MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?	MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?

ALLERGIES OR INTOLERANCE TO MEDICATIONS

Are you allergic to the following? DK (Don't know) ☐ **None**

Latex ☐ Yes ☐ No ☐ DK Metals ☐ Yes ☐ No ☐ DK Local anesthetic ☐ Yes ☐ No ☐ DK Iodine ☐ Yes ☐ No ☐ DK
Ibuprofen ☐ Yes ☐ No ☐ DK Sulfa/Sulfite ☐ Yes ☐ No ☐ DK Codeine ☐ Yes ☐ No ☐ DK Aspirin ☐ Yes ☐ No ☐ DK
Penicillin ☐ Yes ☐ No ☐ DK Other ANTIBIOTICS ☐ Yes ☐ No ☐ DK Other ☐

PERSONAL MEDICAL HISTORY: Do you have now (current) or have had (past) any of the following conditions?					
CONDITION	CURRENT	PAST	CONDITION	CURRENT	PAST
ADD/ADHD			Eating Disorders (anorexia, bulimia, etc.)		
Alcohol/Drug abuse			Gastroesophageal Reflux (heartburn/GERD)		
Anxiety			Heart Issues		
Asthma/breathing problems			HIV/AIDS		
Bladder/Kidney problems			Rheumatic Fever		
Bleeding disorder			Seizure/Epilepsy		
Cancer			Sleep Apnea		
Congenital Methemoglobinemia			Special needs		
Depression			Thyroid Disease		
Diabetes			Weight issues		
Do you have active Tuberculosis/TB					

BIRTH AND PREGNANCY

What city was your child born in? _____ Name of hospital: _____

Is this your child by: ☐ Birth ☐ Adoption ☐ Step-child ☐ Other: _____

Birth weight: _____ Was your baby premature? ☐ Yes ☐ No

Were there any significant medical problems during your pregnancy? ☐ Yes ☐ No

Were there any significant complications during labor or the baby's newborn period? ☐ Yes ☐ No

If yes, to any of the above questions, please explain:

_____

How long was your child breast-fed? ☐ N/A ☐ less than 6 months ☐ 6-11mo ☐ 12-17 mo ☐ 18-23mo ☐ 2 years or more

How long was your child bottle-fed? ☐ N/A ☐ less than 6 months ☐ 6-11mo ☐ 12-17 mo ☐ 18-23mo ☐ 2 years or more

Does/Did your child sleep with a bottle? ☐ Yes ☐ No If Yes, content of bottle? _____

Does/Did your child use a no-spill training cup (sippy cup)? ☐ Yes ☐ No

Child's age (in months) when first tooth appeared in mouth _____

Has your child experience any teething problems? ☐ Yes ☐ No

When did you begin brushing his/her teeth? ☐ N/A ☐ less than 6 months ☐ 6-11mo ☐ 12-17 mo ☐ 18-23mo ☐ 2 years or more

When did you begin using tooth paste? ☐ N/A ☐ less than 6 months ☐ 6-11mo ☐ 12-17 mo ☐ 18-23mo ☐ 2 years or more

Who is your child's primary care taker during the day? _____ During the evening? _____

Name/age of siblings at home:_____

GROWTH AND DEVELOPMENT

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)? ☐ Yes ☐ No

If yes, please explain: _____

Girls only: Age at first period: _____ Are you pregnant? ☐ Yes ☐ No

FAMILY HISTORY-Indicate which relative has had the following disease (parents and siblings are most important)

Are you adopted and have no known family history? ☐ Yes ☐ No

Disease	Mother	Father	Siblings	Disease	Mother	Father	Siblings	Disease	Mother	Father	Siblings
No significant history known				Depression/Suicide/ Anxiety				High Cholesterol			
Alcohol abuse/Drug abuse				Diabetes				Hypothyroidism/Thyroid Disease			
Autoimmune Disease				Heart Disease				Kidney Disease			
Cancer				High Blood Pressure/ Hypertension							

Safety: ☐ **Decline to answer**

Do you use a bike helmet?	☐ Yes	☐ No
Do you use seatbelts consistently?	☐ Yes	☐ No
Does your home have a working smoke detector?	☐ Yes	☐ No
If you have guns in your home, are they locked up?	☐ Yes	☐ No
Is violence at home a concern for you?	☐ Yes	☐ No

Education level:
Highest grade completed :_____

DENTAL HISTORY

Are your teeth sensitive to the cold, hot, sweets or pressure?	☐ Yes ☐No☐ DK	Do you have any clicking, popping or discomfort in the jaw?	☐ Yes ☐No☐ DK
Are you experiencing dental pain or discomfort?	☐ Yes ☐No☐ DK	Do you brux (clench) or grind your teeth?	☐ Yes ☐No☐ DK
Do you have any oral piercing/jewelry?	☐ Yes ☐No☐ DK	Oral habits (chewing finger nails, clenching, etc.)	☐ Yes ☐No☐ DK
Is your mouth dry?	☐ Yes ☐No☐ DK	Do you have any sores or ulcers in your mouth?	☐ Yes ☐No☐ DK
Have you had any periodontal (gum) treatments?	☐ Yes ☐No☐ DK	Have you ever had orthodontic (braces) treatment?	☐ Yes ☐No☐ DK
Do you bleach you teeth?	☐ Yes ☐No☐ DK	Do you wear a mouth guard when playing contact sports?	☐ Yes ☐No☐ DK
Have you had any problems associated with previous dental treatment?	☐ Yes ☐No☐ DK	Have you ever had a serious injury to your head or mouth?	☐ Yes ☐No☐ DK
How many times do you brush daily?		How many times do you floss daily?	

How do you feel about your smile?

Do you drink blotted water or filtered water? ☐ Yes ☐ No ☐ DK

If yes how often? ☐ Daily ☐ Weekly ☐ Occasionally

Date of your last dental exam: _____ ☐ Unknown

What was done at the time_____ ☐ Unknown

Date of your last X-rays: _____ ☐ Unknown

Has your physician or previous dentist recommended that you take antibiotics prior to your dental treatment: □Yes □No □DK
Name of physician or dentist making this recommendation: □ Unknown

_____ _____

Signature Date