TORRANCE MEMORIAL
PHYSICIAN NETWORK

INITIAL PEDIATRIC HEALTH HISTORY FORM

Today's date: _____

Patient's Last Name	First	Middle Initial	Sex ☐ Male ☐ Female
Date of Birth:	Age: _____Years _____Months	Primary care Physician:	

REASON FOR VISIT:

☐ Routine Check-up
☐ Problem visit

Please provide a brief description): _____
How long has this been a problem?_____
How severe is this problem? ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating
How frequent is the problem?☐ Constant ☐ Daily ☐ Weekly ☐ Random
Problem is aggravated by: _____
Relieved by: _____

Medications:

Please list any medications your child is taking, including over-the-counter and prescription medications, vitamins, or herbal medications:

Medication Name & Strength	Dose	How Often	For what condition

ALLERGIES: ☐ Yes ☐ No

Food(s): _____ Reaction: _____
Food(s): _____ Reaction: _____
Food(s): _____ Reaction: _____

Medication(s): _____ Reaction: _____
Medication(s): _____ Reaction: _____

Other: _____ Reaction: _____
Other: _____ Reaction: _____

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Patient Name: _____ Date of Birth: _____

CHILD'S BIRTH HISTORY:

Birth Weight: _____ lbs, _____ oz Hospital of Birth: _____

Mother's age at child's delivery: _____ # of Pregnancies: _____ # of living children: _____

Did child's mother have any illnesses or problems during her pregnancy? If yes, please explain: ☐ No ☐ Yes: _____

Did child's mother use cigarettes, alcohol, drugs, or any medications (other than vitamins and iron) during pregnancy? ☐ No ☐ Yes: _____

Any problems during labor or delivery? ☐ No ☐ Yes: _____

Was the baby premature? ☐ No ☐ Yes: _____

Age baby went home from Hospital: _____

DEVELOPMENTAL HISTORY:

At what age did your child:

_____ Rollover
_____ Sit Alone
_____ Walk Alone
_____ Say first words
_____ Speak two word sentences
_____ Toilet Train

Serious Illnesses, injuries, hospitalizations and surgeries:

Year	Illness/Injury/Hospitalization/Surgery	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Physicians/Health Care providers who care for your child:

Name	Specialty	Contact Information
_____	_____	_____
_____	_____	_____
_____	_____	_____

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FAMILY MEDICAL PROBLEMS: Please identify any medical problems blood relatives have or have ever had:

Condition	No	Yes	Family Member(s)	Condition	No	Yes	Family Member(s)
Birth Defects	☐	☐		Kidney Disease	☐	☐	
Inherited Family diseases	☐	☐		Diabetes	☐	☐	
Childhood Deaths	☐	☐		Thyroid Diseases	☐	☐	
Mental Retardation	☐	☐		Anemia/Blood Disorders	☐	☐	
Seizures/Convulsions	☐	☐		Bone/joint disorders	☐	☐	
Mental Disease/Disorder	☐	☐		Rheumatoid arthritis	☐	☐	
Autism	☐	☐		Muscle Disorders	☐	☐	
ADD/ADHD	☐	☐		Skin Disease	☐	☐	
Eye or Ear Disorders	☐	☐		Cancer	☐	☐	
Allergies, hay fever, eczema	☐	☐		Rheumatic Fever	☐	☐	
Asthma	☐	☐		Tuberculosis	☐	☐	
Heart Disease	☐	☐		Venereal Disease	☐	☐	
Elevated cholesterol	☐	☐		HIV/AIDS	☐	☐	
Heart attack at age <50 years	☐	☐		Smoke regularly	☐	☐	
High blood pressure	☐	☐		Other:_____	☐	☐	
Stomach, Intestinal problems	☐	☐		Other:_____	☐	☐	

SOCIAL HISTORY:

Race: _____ Ethnicity: _____

Preferred Language: _____ Need Interpreter? ☐ No ☐ Yes

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Parents are: ☐ Married ☐ Not Married ☐ Separated ☐ Divorced ☐ Deceased

Child Lives with: ☐ Mother ☐ Father ☐ Siblings ☐ Others (Please list below)

Others in Home: _____

_____

_____

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PAST MEDICAL PROBLEMS: Has your child ever had or now have any of the following?

INFECTION	No	Yes	Doctor's Notes
Measles (10 Days), Mumps	☐	☐	
Rubella (3 days measles)	☐	☐	
Chicken Pox	☐	☐	
Whooping Cough	☐	☐	
Hepatitis	☐	☐	
Eyes	☐	☐	
Crossed or Wandering eyes	☐	☐	
Vision problems	☐	☐	
Recurrent infection, Pink Eye	☐	☐	
EARS			
Frequent ear infections, ear tubes	☐	☐	
Hearing problems	☐	☐	
Difficulty talking	☐	☐	
Stuttering	☐	☐	
MOUTH			
Been to a dentist	☐	☐	
Date of last visit: _____			
Dental problems	☐	☐	
Nose and throat	☐	☐	
Frequent sore throats or tonsil infection	☐	☐	
Persistent hoarseness	☐	☐	
Frequent nose bleeds	☐	☐	
Frequent stuffed up nose/nasal allergies	☐	☐	
Tendency to breathe through his/her mouth	☐	☐	
LUNGS			
Tendency to wheeze, history of asthma	☐	☐	
Repeated coughing spells, or chronic cough	☐	☐	
Pneumonia, bronchitis	☐	☐	
HEART			
Heart murmur	☐	☐	
Irregular heartbeat	☐	☐	
High blood pressure	☐	☐	
Abnormal cholesterol test	☐	☐	
NERVOUS SYSTEM			
Dizzy or fainting spells	☐	☐	
Convulsion, seizures	☐	☐	
Difficulty walking, balancing, or handling objects	☐	☐	
Frequent headaches	☐	☐	
Attention Deficit Disorder	☐	☐	
Musculoskeletal System	☐	☐	
Painful/swollen joints	☐	☐	
Sprains/dislocations, or broken bones	☐	☐	
Posture problems, scoliosis	☐	☐	
Muscle coordination or strength problems	☐	☐	

SKIN	No	Yes	Doctor's Notes
Slow healing bruises	☐	☐	
Persistent rashes	☐	☐	
DIGESTIVE SYSTEM			
Frequent stomach aches	☐	☐	
Frequent diarrhea	☐	☐	
Frequent constipation	☐	☐	
Frequent nausea/vomiting	☐	☐	
Worms/parasites	☐	☐	
Bloody or black stools	☐	☐	
A special dies or food restriction	☐	☐	
Ulcers	☐	☐	
GENITOURINARY SYSTEM			
Painful, burning urination	☐	☐	
Blood in urine	☐	☐	
Bed-wetting problems	☐	☐	
Bladder or kidney infection	☐	☐	
Discharge from vagina or penis	☐	☐	
For girls: Menstrual periods	☐	☐	
Age of onset: _____			
GENERAL	☐	☐	
Anemia/blood disorder	☐	☐	
Excess thirst	☐	☐	
Marked in/decrease in appetite	☐	☐	
Unusual sensitivity to cold or heat	☐	☐	
Eaten paint, dirt, plaster	☐	☐	
Been persistently tired	☐	☐	
Unusually slow healing scrapes, cuts, wounds	☐	☐	
Recurrent fevers	☐	☐	
Taken medication for more than 3 months	☐	☐	
Within the past 6 months has your child:			
Had frequent nightmares	☐	☐	
Been usually nervous	☐	☐	
Has persistent sadness	☐	☐	
Been unusually disobedient	☐	☐	
Been having problems with friends in school	☐	☐	
Other *(please describe)*	☐	☐	

_____
_____
_____
_____
_____
_____
_____