Sawgrass Pediatrics

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HEALTH HISTORY FORM

Patient Name _____ **DOB** _____ **Date** _____

BIRTH HISTORY

Where was your child born? (Hospital Name or City)

What was his or her birth weight?

Was he/she full term? Yes ☐ No ☐
If not, how many weeks early or late was he/she?

Were there any complications during pregnancy? Yes ☐ No ☐
If yes, what were they?

Was the delivery of your child Vaginal ☐ C-section ☐

Were there any complications during delivery? Yes ☐ No ☐
If yes, what were they?

Were there any complications for the baby? Yes ☐ No ☐
If yes, what were they?

Was the baby in NICU (Newborn Intensive Care Unit)? Yes ☐ No ☐
If yes, how long? And why was he/she in NICU?

Did the baby require phototherapy (light therapy) for jaundice? Yes ☐ No ☐

MEDICATIONS

Taking any medications If yes, what? (including vitamins, over the counter medications and prescriptions) Yes ☐ No ☐

Allergic to any medications? If yes, what medication(s) and what reaction(s)? Yes ☐ No ☐

ALLERGIES

Allergic to any foods? If yes, what foods? Yes ☐ No ☐

Allergic to anything in the environment? If yes, to what? Yes ☐ No ☐

Are these allergies? Suspected ☐ Definite (Tested) ☐

Please describe any other birth complications:

PAST ILLNESSES, HOSPITALIZATIONS

Was your child ever admitted to the hospital overnight? If so, when? For what? Yes ☐ No ☐

Have you ever had to take your child to the emergency room? If yes, what for? Yes ☐ No ☐

Please describe:

SURGICAL HISTORY – Has your child ever had surgery? If yes please check the individual boxes

Head or Skull	☐	Cochlear Device	☐		☐	Pyloric Stenosis Repair	☐	**Testicular Surgery**	☐
Eyes	☐	**Tonsils**	☐	Chest Tube	☐	Kidney Surgery	☐	Torsion Reduction	☐
Ears	☐	**Adenoids**	☐	**Gastrointestinal**	☐	**Urological Surgery**	☐	Undescended Testicle	☐
Tear Duct Probe	☐	**Oral Surgery**	☐	Upper Endoscopy	☐	Circumcision	☐	**Orthopedic Surgery**	☐
Strabismus Correction	☐	**Sinus**	☐	Colonscopy	☐	Chordee Release	☐	Scoliosis	☐
Ear Tubes	☐	**Neck**	☐	**Abdominal Surgery**	☐	Hypospadias Repair	☐	Setting Bone Fracture	☐
Ear Tube Removal	☐	**Heart Surgery**	☐	Appendectomy	☐	Hydrocele Repair	☐	**Neurologic**	☐
Ear Drum Repair	☐	Lung Surgery	☐	Inguinal Hernia Repair	☐	Meatoplasty	☐	**Dermatologic/Skin**	☐
Cholesteotoma	☐	Brochoscopy	☐	Umbilical Hernia Repair	☐	**Bladder Surgery**	☐		

PAST MEDICAL HISTORY – If There is No Past Medical History Check Here ☐ (otherwise check the individual boxes)

Skin Problems	☐	**Cardiac Problems**	☐	**Gynecologic Issues**	☐	**Neurological Disorders**	☐	Has your child had a poistive PPD Test	☐
Acne	☐	Murmurs	☐	**Rheumatology Disorders**	☐	Headaches	☐		
Eczema	☐	Heart Defects	☐	Rheumatoid Arthritis	☐	Febrile Seizures	☐	**Oncology Disease (Cancer)**	
Eye/Vision Problems	☐	High Cholesterol	☐	Lupus	☐	Epilepsy	☐		
Glasses for Reading	☐	**Stomach Intestinal Disorders**	☐	**Endocrine Disorders**	☐	**Developmental Delay**	☐		
Glasses for Distance	☐	GERD (Heartburn)	☐	Diabetes Type I (Child)	☐	Speech/Language Delay	☐		
Ear/Nose/Throat	☐	Constipation	☐	Diabetes Type II (Adult)	☐	Fine Motor Delay	☐	Please Describe	
Recurrent Ear Infections	☐	Irritable Bowel	☐	Thyroid Disease	☐	Social Delay	☐		
Recurrent Sinus Infections	☐	Ulcerative Colitis	☐	**Orthopedic Disorders**	☐	Cognitive Delay	☐		
Hearing Loss	☐	Crohn's Disease	☐	Fractures in the Past	☐	**Psychiatric Disorders**	☐		
Allergies	☐	Pyloric Stenosis	☐	Scoliosis	☐	ADD/ADHD	☐	**Immune Disorders**	☐
Respiratory Problems	☐	**Renal/Kidney Disease**	☐	**Blood Disorders**	☐	Depression	☐	Please Describe	
Asthma	☐	Polycystic Kidney	☐	Anemia	☐	**Genetic Disorders**	☐		
Pneumonia	☐	Proteinuria	☐	Bleeding Disorders	☐		☐		
Cystic Fibrosis	☐	Urine Reflux	☐	Low Platelets	☐		☐		

Any Other Past Medical History Not Mentioned

(See Reverse Side For More Questions)

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HEALTH HISTORY FORM

FAMILY HISTORY If yes please check **Please include the PATIENT'S, parents, grandparents, aunts, uncles, brothers, sisters, first cousins**

If There is No Family History of Disease Check Here ☐ (otherwise check the individual boxes)

Heart Disease	☐	Asthma	☐	Crohn's Disease	☐	Psychiatric Disorder	☐	**No History Available**	☐
High Blood Pressure	☐	Emphysema	☐	Bleeding or Clotting Disorder	☐	ADD/ADHD	☐	Adopted	☐
High Cholesterol	☐	Cystic Fibrosis	☐	Immune Defect	☐	Birth Defects	☐		☐
Diabetes Type I (Child)	☐	Tuberculosis	☐	HIV Infection	☐	Any Other Past Medical History Not Mentioned			
Diabetes Type II (Adult)	☐	Hepatitis	☐	Arthritis	☐				
Cancer	☐	Allergies	☐	Seizure Disorder	☐				
Thyroid Disease	☐	Cirrhosis of the liver	☐	Stroke	☐				
Kidney Disease	☐	Ulcerative Colitis	☐	Neurologic Disorder	☐				

SOCIAL BACKGROUND

CHILD LIVES WITH		**Both Parents (Married)**	☐	**Guardian/Other**	☐	**Child Lives In**		**PETS AT HOME**	
Mother	☐	**Father**	☐	Grandparent(s) in the Home	☐	House	☐	Dogs (s)	☐
Separated	☐	Separated	☐	Grandparent(s) as Guardian	☐	Apartment/Condo	☐	Cat (s)	☐
Divorced	☐	Divorced	☐					Bird (s)	☐
Joint Custody	☐	Joint Custody	☐	Other Relatives in the Home	☐			Fish (s)	☐
Sole Custody	☐	Sole Custody	☐	Other Relatives as Guardian	☐			Lizard/Turtle	☐
W/Stepfather	☐	W/Stepfather	☐	**Please Indicate Name of Guardian if other than Mom or Dad:**				Other	
W/Stepbrother	☐	W/Stepbrother	☐						
W/Stepsister	☐	W/Stepsister	☐						
Mother's Occupation		**Father's Occupation**							

ETHNIC BACKGROUND		**NATIVE LANGUAGE**		**SMOKING/DRUGS/ALCOHOL**		
Caucasian	☐	English	☐	Does anyone smoke inside or outside the house?	Yes ☐	No ☐
Hispanic	☐	**Spanish**	☐	**FOR PATIENTS 13 OR OLDER**		
African American	☐	Creole	☐			
Asian	☐	Other (please specify)		History of Drug Use	Yes ☐	No ☐
American Indian	☐			History of Alcohol Use	Yes ☐	No ☐
Haitian	☐			History of Tobacco Use	Yes ☐	No ☐
Other	☐					

Pharmacy Information: All Prescriptions will be sent electronically – you will no longer receive paper prescriptions

Name and Phone Number of your Pharmacy	**Address or Cross Streets of your Pharmacy**

Please describe any other problems with your child where we may be able to help:

Parent/Guardian Signature _____ **Date** _____