



# Family Medicine of Lincoln

BRYANLGH PHYSICIAN NETWORK  
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## PEDIATRIC HEALTH HISTORY FORM

Welcome to Family Medicine of Lincoln! To better serve / treat your child we ask that you please fill out this history form to the best of your knowledge.

Date Completed: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: Male Female DOB: \_\_\_\_\_

What grade in school: \_\_\_\_\_ What School: \_\_\_\_\_

### ILLNESS AND INJURIES: HAVE YOU EVER HAD...

	YES	NO		YES	NO
Mumps			Knocked unconscious		
Measles			Tonsillitis		
German Measles			Urinary tract infection		
Chicken pox			Ear infection(s)		
Seizures			Pneumonia		
Asthma			Meningitis		
Allergies			Feeding Problems		
Poison ingestion			Heart Murmur		
Broken Bones			Vision problems		

### ALLERGIES OR REACTIONS ( ) NONE

DRUG	DATE OF REACTION	WHAT HAPPENED?

### MEDICATIONS CURRENTLY TAKEN ( ) NONE

DRUG	HOW OFTEN	WHAT FOR?

### HOSPITAL, SURGERY, OTHER MAJOR ILLNESS OR INJURY

DATE	Describe why hospitalized, nature of surgery, what illness

Is your child up to date on all immunizations? YES NO UNSURE  
Please provide a copy of his/her immunization records.

### MATERNAL HISTORY

Mother's age when this child was born:	Medical problem during this pregnancy: (Illnesses, infections, anemia, blood pressure, etc.)		
Number of pregnancies prior to this child:			
Medications taken during pregnancy: List	# of days mother in hospital after birth:	Prenatal care was provided by:	

### BIRTH HISTORY

Where born:	Hours in Labor:	Problems or complications of delivery?
Who delivered baby:	Labor was: ( ) Spontaneous ( ) Induced	
Weight _____ Length _____	Was medication given during labor? ( ) Yes ( ) No	
Was baby born within 2 weeks of expected day? ( ) Yes ( ) No ( ) Early ( ) Late	Delivery was:	
	( ) Spontaneous vaginal delivery ( ) Cesarean section	
	( ) Forceps	
	Baby position:	
	( ) Head first ( ) Feet/bottom first	

### NEWBORN HISTORY (FIRST FEW DAYS OF LIFE)

	YES	NO
Baby cried or breathed spontaneously within 1 or 2 minutes?		
Was baby jaundiced (yellow)?		
How many days in hospital?		
Baby's problems or complications:		
Was child breast fed? ( ) Yes ( ) No    How long? _____		
Type of Formula		

### DEVELOPMENTAL HISTORY

	AGE IN MONTHS
If not done currently leave blank	
Roll stomach to back	
Laugh out loud	
Reach out for objects	
Sit without support	
Feed self crackers	
Say dada, mama in reference to right person	
Drink from a cup	
Walk well	
Toilet trained (daytime)	
Combine (2 words)	
	AGE IN YEARS
Give first and last name	
Dress self	

### SOCIAL HISTORY: Give your brief assessment in 2-3 words of your child's:

Personality	
Ways of comforting self	
Expression of anger/frustration	
Cooperation/obedience	
Fears	
Self-satisfaction/degree of happiness	
Reaction to change	
Relationship to other children	
Number of close friends	
School performance	
What concerns you most about this child?	

**HAVE ANY OF YOUR CHILD'S BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING?**

	YES	NO
Anemia		
Arthritis		
Birth defect		
Bleeding tendency		
Cancer		
Deafness		
Diabetes mellitus		
Drinking or drug problem		
Epilepsy/seizures		
Glaucoma		
Heart attack or heart disease		
High blood pressure		
Mental or emotional problems		
Nerve or muscle disease		
Obesity		
Stroke		
Suicide or attempted suicide		
Tuberculosis		
Other (please list below)		

**PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS**

NAME(S)	MALE/FEMALE	DATE OF BIRTH OR AGE	LIVING AT HOME?
Mother:			
Father:			
Children:			
Others living in household:			

Parent or legal guardians signature: \_\_\_\_\_ Date: \_\_\_\_\_

**UPDATE TO MEDICAL PROFILE - FOR CLINIC USE ONLY**

DATE	PHYSICIAN	INITIALS	DATE	PHYSICIAN	INITIALS