**GVSU Family Health Center**

**Pediatric Medical History**

**Is your child** Biological Adopted Foster Guardian

**Prenatal Care** Yes No

**Maternal Problems During Pregnancy**

Prescription Medications Diabetes

Street Drugs High Blood Pressure

Smoking STD

Alcohol Use Infections

Other

**Where was your child born?** Home Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delivery** Vaginal C-Section, why:

fetal distress repeat failure to progress other

**Complications in the Nursery** None

Infection Birth Defects

Feeding Issues Heart Murmur/Defects

Apnea Breathing Problems

Jaundice Kidney Defects

Surgery Sickle Cell Trait/Disease

Chromosome Abnormality Seizures

Metabolic Problems Other

How long did your child stay in the hospital after birth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Gestation/What was your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child is older than 1 year, is he/she still taking a bottle or breastfeeding? Yes No

 If so, how often does your child nurse or get a bottle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What is generally in the bottle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you put your baby to bed with a bottle? Yes No

Does your child take any medications? Yes No

Does your child live with anyone or visit anyone regularly who uses tobacco? Yes No

Does your child have any allergies? Yes No

 If yes, what is your child allergic to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been in the hospital overnight for any reason (other than the newborn nursery)? Yes No If yes: Problem/Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had surgery? Yes No If yes:

Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Has your child ever had a seizure? Yes No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had a urinary tract infection (UTI) or been diagnosed with any kidney disorders? Yes No If yes, how many UTIs? \_\_\_\_\_\_\_\_\_

Kidney diagnosis/disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been told that your child has a heart murmur or other heart defect? Yes No

 If yes, has your child seen a heart specialist/cardiologist? Yes No

 Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had trouble with wheezing, asthma, bronchitis, pneumonia or cystic fibrosis?

 Yes No If yes, please circle which one(s)

Does your child get frequent ear infections? Yes No

If yes, has he/she seen a specialist? Yes No

Has your child ever had the Chicken Pox? Yes No If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had Scarlet Fever/Rheumatic Fever? Yes No If yes, when: \_\_\_\_\_\_\_

Does your child have any recurrent skin problems? Yes No If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been told that your child has low iron? Yes No

If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have problems with frequent or prolonged bleeding? Yes No

 If yes, diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has your child seen a specialist?\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been a victim of emotional, sexual or physical abuse? Yes No

Has your child ever had any broken bones, sprains, strains, concussions? Yes No

Does your child see a dentist regularly? Yes No Any dental problems? Yes No

Has your child ever had a blood transfusion? Yes No

Has your child ever had an organ transplant? Yes No

Does your child have any problems with sleeping or snoring? Yes No

Does your child get frequent headaches? Yes No

If your child is older than 8 years of age, does he/she wet the bed? Yes No

**Has your child ever been diagnosed with any of the following (circle all that apply)?**

Sickle Cell Disease Liver Disease Depression

Sickle Cell Trait Hepatitis Anxiety

Vision Problems Diabetes ADD/ADHD

Hearing Problems Cancer Suicide Attempts

TB/Tuberculosis High Cholesterol Muscular Dystrophy

High Blood Pressure Mental Retardation Rheumatoid Arthritis

STDs Thyroid Disorder Eating Disorders

Obesity Overweight High Lead Level

AIDS/HIV

**For GIRLS ONLY**

Has your daughter started her period yet? Yes No

If yes, at what age was the first period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was her last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any issues with her period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTES:**

**GVSU Family HEalth Center**

**Newborn/Pediatric Social History**

Who lives in the household with the child?

Are mother and father? married, living together, never married, divorced, separated

Who is the main caregiver for this child?

Does your child attend day care? Yes/no; if so, how many hours/week

Does mom work? Yes/no; if so, full time or part time

Does dad work? Yes/no; if so, full time or part time

Does your child use a car seat regularly? Yes/no

 If your child is under 2 years of age, is he/she in a rear facing car seat? Yes/no

If your child is between 2 and 4 years, is he/she in a forward facing car seat with a 5 point harness? Yes/no

If your child is over 4 years of age and under 57 inches, is he/she in a booster seat? Yes/no

If your child is under the age of 13 year:

Does he/she ride in the front seat? Yes/no

Does he/she wear a seatbelt at all time while riding in a car? Yes/no

Do you have a smoke detector in your house? Yes/no

Do you have a carbon monoxide detector in your house? Yes/no

Do you have any guns in your house? Yes/no; if yes, are the guns locked up and unloaded? Yes/no

Are there any pets in the house? Yes/no

What kind of water do you have? well water city water

**GVSU Family HEalth Center**

**Family Medical History**

Alcohol abuse? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/Hay fever? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma/Wheezing? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADD/ADHD? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth defects? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorder? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer? Yes/No What kind?­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chromosome Abnormality? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cystic Fibrosis/Lung disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug abuse? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy/Seizures? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Problems? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease/Heart Attacks (before age 55) Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis/Liver disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/AIDS/Immune Problems? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental illness/depression? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Retardation? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Muscular Dystrophy? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rheumatoid arthritis? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually transmitted diseases? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sickle Cell? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision or eye problems? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any family member had an unexplained, unexpected death before age 50? Yes/No