

McKinney Pediatrics
 1872 N. Lake Forest Drive, McKinney, Texas 75071

Pediatric Health History

Your child's health is of the utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information is treated confidentially.

Date: _____
 Child's Name: _____ Date of Birth: _____ Age: _____ M F
 Mother's Name: _____ Home Phone: _____ Work Phone: _____
 Father's Name: _____ Home Phone: _____ Work Phone: _____
 Child's School: _____ Grade: _____
 Previous Physician: _____ Phone: _____ City/State: _____

DRUG ALLERGIES		MEDICATIONS	
Substance	Reaction	Medication Name	Dosage

MEDICAL HISTORY

Please check if the child has ever had any of the following:

	CARDIOVASCULAR	GASTRONINTESTINAL	MUSCLE/JOINT/BONE	NOSE/THROAT/CHEST
Anemia	Murmurs	Poor Appetite	Broken Bones	Difficulty Breathing
Asthma	Chest Pain	Bloody/Dark Stool	Sprains	Difficulty Swallowing
Bronchitis	Irregular heart beat	Constipation	Coordination Problems	Frequent Colds
Chicken Pox	EYES	Diarrhea	Posture Problems	Hoarseness
Hepatitis	Crossed or wandering	Excessive Hunger	Pain, weakness or swelling	Mouth-Breathing
Measles	Eye Irritation	Excessive Thirst	GENERAL	Nosebleeds
Rubella	Vision Problems	Nausea	Chills	Persistent Cough
Mumps	HEARING/SPEECH	Rectal Bleeding	Depression	Sinus Problems
Rheumatic Fever	Difficulty Hearing	Stomachaches	Dizziness	Sore Throat
Pneumonia	Earaches	Vomiting	Fainting	Strep Throat
Whooping Cough	Ear Infections	Worms	Forgetfulness	Tonsil Infections
RSV	Speech Problems	GENITO-URINARY	Headaches	Wheezing
DENTAL	Other:	Bedwetting	Loss of Sleep	SKIN
Bleeding Gums		Blood in Urine	Mood Swings	Bruise Easily
Grinding Teeth		Diaper Rash, Persistent	Nervousness	Change in Moles
Sensitivity		Discharge (vagina/penis)	Numbness	Hives
Thumb Sucking		Frequent Urination	Sweating	Rash
Last dental Check Up:		Painful Urination	Tiredness	Scares
Brush, how often?		Unusual Urine Order	Weight Loss/Gain	Sores that won't heal
Floss, how often?				

HOSPITALIZATIONS			INJURIES		
Reason	Date	Hospital, City, State	Serious Injuries/Illness	Date	Outcome

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PRENATAL AND INFANT HEALTH HISTORY

Place of birth:		OB:		Mom's age at birth:	
During pregnancy, which of these conditions did you have? (Please check all that apply)					
Alcohol Use	German Measles	Venereal Disease			
Anemia	Hepatitis	Non-Prescription drug use:			
Diabetes	High Blood Pressure	Prescription drug use:			
Edema/Swelling	Protein in Urine	Controlled Substance drug use:			
Exposure to chemicals or radiation	Tobacco Use	Other:			
Fever	Urinary Tract Infection				

DELIVERY (Please circle all that apply):

On Time Premature Late Normal Delivery Induced /Prolonged Breech C-Section

Please describe any other complications:							
Birth Weight:		Lbs.		Oz.	Birth Defects:		
Discharge Weight:		Lbs		Oz.	Breathing Problems	Jaundice	Transfusion
Length:					Feeding (circle one):		
Age at discharge:					Breast	Formula	Both

FAMILY HISTORY

	Age	General Health		Name	Age	General Health
Father			Sibling			
Mother			Sibling			

Please circle any condition that any of the child's blood relatives have had and their relationship:

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Alcoholism		HIV/AIDS	
Allergies		Kidney Disorder	
Anemia		Lung Disorder	
Arthritis		Mental Disease/Disorder	
Asthma/Emphysema		Mental Retardation	
Birth Defects		Muscular Disorder	
Bone/Joint Disorders		Rheumatic Fever	
Cancer		Seizure/Convulsions	
Diabetes		Sickle Cell Disease	
Epilepsy		Skin Disease	
Eye or Ear Disorder		Stroke	
Genetic Defects		Thyroid Disorder	
Heart Disease		TB	
Hemophilia		Venereal Disease	
High Blood Pressure		Other:	

I acknowledge that the information contained herein is correct to the best of my knowledge.

Signature:		Relationship to patient:	
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