



PEDIATRIC HEALTH ASSESSMENT

Patient's Name: _____ Date of Birth: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Parents Marital Status: Married _____ Single _____ Widowed _____ Divorced _____
Living Together _____ Separated _____

Parental involvement in child care: Father Yes / No Mother Yes / No

What language do you or your child best understand _____

Who lives in the household _____

Family Physician or Pediatrician: _____

How do you or your child best learn:

- a. One on One Instruction _____
- b. Audio Visual Information _____
- c. Written Information _____
- d. Group Instruction _____
- e. Demonstration/Practice _____
- f. Other _____

Is your child exposed to anyone who uses tobacco? Yes / No Who? _____

Does anyone in the household consume alcohol? Yes / No

Does anyone in the household use any other substances Yes / No If yes, type _____

Is your child afraid of anyone? Yes / No

Has your child ever been physically or emotionally hurt by anyone: Yes / No

Are there pets in the household? Yes / No Type: _____

Water type? City / Well

School District _____

School Concerns: Yes / No

Does your child wear a bike helmet? Yes / No

Does your child use a car seat, booster seat, or seat belt? Yes / No

Do you or your child have any special needs we should be aware of so that we can better serve you?

Updated				
Reviewed By				

OVER



PEDIATRIC HEALTH ASSESSMENT

Previous Surgery

Complications

Date

Name of Current Medications:

Does your child have allergies? Yes / No If yes, please list:

Medications: _____

Environmental: _____

Immunizations up to date Yes No

Has the patient ever had or experienced any of the following:

General

Weight loss Yes No
 Weight gain Yes No

Eyes

Glasses/Contact Yes No

ENT

Hearing problems Yes No

Cardiovascular

Heart murmur Yes No
 Chest pain Yes No
 High blood pressure Yes No
 Fainting Yes No

Respiratory

Asthma/wheezing Yes No
 Bronchitis/Pneumonia Yes No
 Sleep Apnea Yes No
 Home oxygen therapy Yes No
 Shortness of breath Yes No
 Cystic Fibrosis Yes No

GI

Difficulty swallowing Yes No
 Diarrhea Yes No
 Reflux Yes No
 Blood in stool Yes No
 Constipation Yes No

Musculoskeletal

Scoliosis Yes No

Integumentary

Rashes Yes No

Neurologic

Seizures Yes No
 Hydrocephalus Yes No
 Developmental Delay Yes No
 Cerebral Palsy Yes No
 Numbness arms/legs Yes No
 Unsteady gait Yes No
 Difficulty speaking Yes No
 Headaches Yes No

GU

Painful voiding/urinating Yes No
 Bed wetting Yes No
 Urinary tract infection Yes No
 Toilet trained Yes No

Hematologic/Lymphatic

Anemia Yes No
 Bleeding disorder Yes No

Endocrine

Diabetes Yes No
 Thyroid disease Yes No

Immunologic

HIV/AIDS Yes No

ImGeneral

Weight loss Yes No
 Weight gain Yes No

Eyes

Glasses/Contact Yes No

Family Medical History:

Diabetes Yes No
 Cancer Yes No
 Heart Disease Yes No
 Anesthesia Complications Yes No

Stroke Yes No
 Hypertension Yes No
 Anemia Yes No
 Blood/Bleeding Disorders Yes No

Childhood Deaths Yes No

Asthma Yes No
 Seizures Yes No
 Arthritis

 Name of Person Completing Form

 Date

 Time

 Relationship to Patient

 Signature of person who reviewed and discussed above with the provider.

 Date

 Time