Sawgrass Pediatrics

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HEALTH HISTORY FORM

«PatientFirstLastName»	«PatientDOB»	«CurrentDate»
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? If not, how many weeks early or late was he/she?	Yes ☐	No ☐
Were there any complications during pregnancy? If yes, what were they?	Yes ☐	No ☐
Was the delivery of your child	Vaginal ☐	C-section ☐
Were there any complications during delivery? If yes, what were they?	Yes ☐	No ☐
Were there any complications for the baby? If yes, what were they?	Yes ☐	No ☐
Was the baby in NICU (Newborn Intensive Care Unit)? If yes, how long? And why was he/she in NICU?	Yes ☐	No ☐
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** ☐	Colonoscopy ☐	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** ☐
Cholesteatoma ☐	Bronchoscopy ☐	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)

Sawgrass Pediatrics

HEALTH HISTORY FORM (page 2) «PatientFirstLastName» DOB: «PatientDOB»

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:

«CurrentDate»

Parent/Guardian Signature **Date**