MountainStar
Lone Peak Family Medicine
affiliated with Lone Peak Hospital

Pediatric Health History Form

Child's Name:_____ Date of Birth:_____
Child's Previous Doctor:_____
Allergies/Reactions to Medications or Vaccines:_____
Current Medications/Vitamins:_____
Current Problems/Concerns:_____

Past Medical History: (*Please Check All That Apply*)

☐ Asthma/Hay Fever/Eczema ☐ Chicken Pox ☐ RSV ☐ TB
☐ Broken Bones ☐ Croup ☐ Attention Problems ☐ Sexual/Physical Abuse
☐ Frequent Ear Infections ☐ Pneumonia ☐ Other_____

(Please explain any "Yes" answers)_____
☐ Hospitalizations/Surgeries (with dates):_____

Immunizations/Exposures/Habits: (Please bring a copy of your child's immunization record to all well child appointments)
Are you child's immunizations up to date? ☐ Yes ☐ No Flu shot this year? ☐ Yes ☐ No
Do any household members smoke? ☐ Yes ☐ No
Marijuana? ☐ Yes ☐ No Alcohol in the home? ☐ Yes ☐ No Other drugs in the home? ☐ Yes ☐ No
Any concerns about lead exposure (old home/plumbing/peeling paint)? ☐ Yes ☐ No
TV, computer, video games: ☐ Yes ☐ No Hours per day_____
Physical activity: ☐ Yes ☐ No Hours per day_____
Pets in the home? ☐ Yes ☐ No Location?_____ If so, vaccinated?

Pregnancy & Birth:
Any problems with the pregnancy? ☐ Yes ☐ No (Please explain) _____
Delivered by: ☐ Vaginal Birth ☐ Cesarean Birth ☐ NICU ☐ Full Gestation

Family History: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions

Alcoholism	_____	High cholesterol	_____
Cancer (specify type)	_____	High blood pressure	_____
Heart disease/Stroke	_____	Kidney disease	_____
Depression/Anxiety	_____	Bleeding/clotting disorder	_____
Genetic Disorders	_____	Asthma/COPD	_____
Diabetes	_____	Seizures	_____
Migraines	_____	Other	_____

Social History:
Who does child live with?
☐ Mom ☐ Dad ☐ Siblings (how many) _____ ☐ Grandma ☐ Grandpa ☐ Other _____
The child's parents are: ☐ Married ☐ Unmarried, but living together ☐ Separated ☐ Divorced
Does you child attend preschool/school? ☐ Yes ☐ No Any concerns at school? ☐ Yes ☐ No, explain_____
Where in AK have lived? _____
Travel around AK in last 12 mos. ☐ Yes ☐ No Travel out of US in last 12 months ☐ Yes ☐ No (where)_____

Review of Systems: (*Please check any current problems your child is experiencing*)

Allergy
☐ Hay fever/itchy eyes
☐ Unexplained weight loss/gain

General
☐ Fevers/chills/excessive sweating
☐ Unexplained weight loss/gain

Eyes
☐ Squinting
☐ Crossed eyes

Ears/Nose/Throat
☐ Unusual loud voice/hard of hearing
☐ Mouth breathing/snoring
☐ Frequent runny nose
☐ Bad breath
☐ Problems with teeth/gums

Respiratory
☐ Coughing/wheezing
☐ Chest pain

Cardiovascular
☐ Tires easily with exertion
☐ Shortness of breath
☐ Fainting

Gastrointestinal
☐ Nausea
☐ Constipation
☐ Blood in bowel movement

Genitourinary
☐ Bedwetting
☐ Pain with urination
☐ Discharge: penis/vagina

Neurological
☐ Headaches
☐ Weakness

Musculoskeletal
☐ Muscle/joint pain

Blood/Lymph
☐ Unexplained lumps
☐ Easy bruising/bleeding

Psychiatric
☐ Speech problems
☐ Depression
☐ Sleep issues

Skin
☐ Rashes
☐ Unusual moles