PEDIATRIC HISTORY
AGES 0-15

Name_____ Birthdate_____
Mother's name_____ Age_____
Father's name_____ Age_____

Birth Weight_____ Height_____
Any problems with the pregnancy? Yes No If yes, what type of problems:
_____
Formula fed? Yes No If yes, type if still on formula_____

Past Medical History:
Hospitalizations (diagnosis and dates):
1.
2.
3.
Surgeries (diagnosis and dates):
1.
2.
3.
Medications (name and dose):
1.
2.
3.
Allergies:
1.
2.
3.
Other Medical Problems:
1.
2.
3.

Family History:
Mother's health problems, if any_____
Father's health problems, if any_____
Siblings' health problems, if any_____
Other significant medical problems in the family? If yes, what_____

Circle All that Apply: High blood pressure Heart disease Cancer (type_____)
Diabetes Asthma TB Cystic fibrosis Blood disease Epilepsy Arthritis
Ulcers Colitis Birth defects Genetic disorders Migraine headaches Depression Alcoholism
Drug abuse AIDS Other_____

Social History:
Who lives at home with the child? (Circle all that apply) Mother Father
Brother(s) Ages_____ Sister(s) Ages_____
What grade is the child in? _____
Does the child go to daycare? Yes No
Does anyone in the home smoke? Yes No
Are there guns in the home? Yes No
Does the child use: Car Seat Seat Belt
Are there pets in the home? Yes No Type_____

Signature of person filling out form_____
Relationship to patient_____

WELL-WOMAN QUESTIONAIRE

NAME _____ DOB _____

1. Age: _____
   First day of last menstrual period (or first year of menstruation, if through menopause): _____
2. Number of times pregnant: _____
   Number of completed pregnancies: _____
   Date of last pregnancy: _____
   If you are under age 55, what method of birth control
   do you use: _____
3. Have you had any of the following problems:
   Abnormal Pap smears O YES O NO
   If yes, date: _____ problem: _____
   For abnormality, did you have nay of the following done:
   Colposcopy O YES O NO
   Biopsies O YES O NO
   Surgery O YES O NO
4. Do you have any of the following:
   a. Bleeding between periods or since periods stopped O YES O NO
   b. A new or enlarging lump in breast O YES O NO
   c. Change in size/firmness of stools O YES O NO
5. Do you have a parent, brother or sister with a history of the following:
   a Cancer of the breast, intestine or female organs O YES O NO
   b. Heart pain or heart attacks before the age of 55 O YES O NO
   If yes to a or b:
   Relation:_____ Type: _____
   Relation _____ Type: _____
6. Osteoporosis (thin-bone) screening:
   a. Is there a history of any relatives with the following: O YES O NO
   Stooping over or losing height as they got older, "thin bones," hip fractures
   If yes, relation: _____
   b. Have you had any of the following:
   Height loss O YES O NO
   Broken hip or wrist O YES O NO
   Bone-density test O YES O NO
7. Have you ever used tobacco? O YES O NO
   If yes:
   Average number of packs/day: _____ Number of years smoked: _____
   Year quit: _____When are you planning to quit?
   O now O next 6 months O sometime O never
8. Prevention:
   a. Exercise:
   Activity _____
   Days per week _____
   Times/duration _____
   Exertion: O stroll O mild O heavy
   b. If over 30 years old, have you had your cholesterol level checked in the past five years? ON/A O YES O NO
   c. Have you ever had a mammogram? O YES O NO
   If yes, date of last: _____ where: _____
   Have you ever had any abnormal mammograms? O YES O NO
   If yes, date: _____ problem: _____
   For abnormality , did you have any of the following?
   Biopsy O YES O NO
   Cyst fluid drained O YES O NO
   Surgery O YES O NO
   d. How many sexual partners have you had in the last 12 months? _____ In your lifetime_____