



Pediatrics of Steamboat Springs

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CHILD HEALTH HISTORY

If YES, please explain.

- | | | | |
|---|-----|-----|-------|
| -Allergies (meds/latex)? | Yes | No | _____ |
| -Daily medications? | Yes | No | _____ |
| -Chronic illness/disability? | Yes | No | _____ |
| -Hospitalizations? | Yes | No | _____ |
| -Surgeries? | Yes | No | _____ |
| -If male, circumcised? | Yes | No | _____ |
| -If female, age of 1 st period | N/A | Yes | _____ |
| -If female, periods normal? | Yes | No | _____ |
| -Had Chicken pox disease? | Yes | No | _____ |
| -Immunizations up to date? | Yes | No | _____ |
- (please provide record)

Past Healthcare Providers: _____

Date of most recent wellness check (if with other provider): _____

Past or current problems with any of the following conditions?

If YES, explain when diagnosed and how treated

- | | | | |
|-----------------------------|-------|----|-------|
| -Vision or hearing | Yes | No | _____ |
| -Frequent ear infections | Yes | No | _____ |
| -Asthma | Yes | No | _____ |
| -Hay Fever/animal allergies | Yes | No | _____ |
| -RSV or Pneumonia | Yes | No | _____ |
| -Seizures | Yes | No | _____ |
| -Bladder/Kidney infection | Yes | No | _____ |
| -Stomach problems | Yes | No | _____ |
| -Injury to joint/bone | Yes | No | _____ |
| -Abuse | Yes | No | _____ |
| -Feeding/eating problems | Yes | No | _____ |
| -Growth/development | Yes | No | _____ |
| -Mental health | Yes | No | _____ |
| -Behavior problems | Yes | No | _____ |
| -School problems | Yes | No | _____ |
| -Tobacco/alcohol/drugs | Yes | No | _____ |
| -Other health problems? | _____ | | |