Pediatrics of Steamboat Springs

940 Central Park Dr. Ste. 201
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Ronald F. Famiglietti, M.D. Sheila M. Fountain, M.D. Dana M. Fitzgerald, M.D.
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Child and Family Health History

CHILD'S NAME:______________________ DATE:___________

PREGNANCY AND BIRTH HISTORY **Please explain all Yes answers**

Regarding **MOTHER** during pregnancy…
-Have any problems or illness? Yes No ___________________________________
-Take any medicines? Yes No
____
-Use tobacco, alcohol, drugs? Yes No ___________________________________
-Have problems with labor/delivery? Yes No ___________________________________
-Length of pregnancy? _____weeks

Regarding **BABY** after delivery…
-Have any health problems? Yes No _________________________________
-Length of hospital stay? _____days____
-Birth weight? _____lbs _____oz
Hepatitis B given in hospital? Yes No Don't Know

SOCIAL HISTORY **Please explain all Yes answers**

-Is child adopted? Yes No ___________________________________
-Are parents divorced? Yes No ___________________________________
-Does child move between multiple homes? Yes No _____________________________
-Who lives with child in the home? ____
-Recent stressors? Yes No ___________________________________ (i.e. death/illness in family, divorce, move)

Past Health Care Providers: ____
Date of most recent wellness check (if with other provider):____________________________

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HEALTH HISTORY **Please explain all Yes answers**

-Medication/Latex allergies? 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 1st period or NA ______________________
-If female, periods normal? Yes No ______________________
-Had chicken pox disease? Yes No ______________________
-Up to date on Immunizations? Yes No __________(please provide record)

Past or current problems with any of the following conditions?
Please explain all Yes answers

-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? ______________________

FAMILY HISTORY (if the answer is yes, please indicate relationship of family member to the patient)

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-Diabetes (insulin dependent) Yes No ________________________________
-Tuberculosis Yes No ________________________________
-Cancer Yes No ________________________________
-Asthma/Allergy Yes No ________________________________
-Seizures Yes No ________________________________
-Deafness Yes No ________________________________
-Mental Illness Yes No ________________________________
-Thyroid disorder Yes No ________________________________
-Joint problems Yes No ________________________________
-Kidney disorder Yes No ________________________________
-Birth defects Yes No ________________________________
-Genetic disorders Yes No ________________________________
-Gastrointestinal disorders Yes No ________________________________
-Heart disease Yes No ________________________________
-Sudden or accidental death Yes No ________________________________
-High Cholesterol Yes No ________________________________