Pediatric Health History Form -- Initial Visit

Child's Name_____ Date of Birth / / / Age _____ ☐ Male ☐ Female
Child's Perferred Name _____ Gender Identity: ☐ Male ☐ Female ☐ Nonbinary ☐ X

Parent's Name _____ Parent's Name _____

Form filled out by _____ Date_____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child Born?_____
Is the child yours by ☐birth ☐adoption ☐stepchild ☐other _____
Delivery by ☐Vaginal ☐C-Section
Reason for c-section_____
Complications _____
Was your child premature ☐No ☐Yes
If yes how many weeks?_____
Any Complications _____
Was your child in the NICU? ☐ Yes ☐ No
If yes how long? _____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with any of the following:

- ☐ Asthma or reactive airway disease
- ☐ Wheezing or bronchiolitis
- ☐ Seasonal allergies or eczema
- ☐ Food allergy
- ☐ Recurrent ear infections
- ☐ Pneumonia
- ☐ Urinary tract infections
- ☐ Genetic Syndrome
- ☐ Seizures
- ☐ Anemia
- ☐ Broken Bone
- ☐ Learning Disability
- ☐ Depression/anxiety

Other chronic medical conditions _____
_____

Has your child ever been hospitalized ☐Yes ☐No
explain:_____
_____

Previous surgeries and dates_____
_____

Is your child allergic to medicine or drugs :
☐Yes ☐No Explain:_____
_____

Social History

Who lives in the childs household?
☐Mom ☐Dad ☐Step ☐Grandparent
☐Other_____ ☐ Siblings (#_____)

Family History

Do any family members have any of the following conditions:

	Mother	Father	Sibling	Grandparent	
Asthma	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Throid disease	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐	☐
Alcholism	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐
Hearing loss	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Developmental Disability	☐	☐	☐	☐	☐
Immune problems	☐	☐	☐	☐	☐

Reviewed by _____
Date: _____

PLEASE ALSO COMPLETE REVERSE SIDE

NYS Health Related Social Needs Screening Questionnaire

Housing/ Utilities		
1. What is your living situation today?	I have a steady place to live I have a place to live today, but I am worried about losing it in the future I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	Pests such as bugs, ants, or mice Mold Lead paint or pipes Lack of heat	Oven or stove not working Smoke detectors missing or not working Water leaks None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes No Already shut off	
Food Security		
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true Sometimes true Never true	
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true Sometimes true Never true	
Transportation		
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes No	
Employment		
7. Do you want help finding or keeping work or a job?	Yes, help finding work Yes, help keeping work I do not need or want help	
Education		
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	Yes No	
Interpersonal Safety **Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.**	**A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe**	
9. How often does anyone, including family and friends, physically hurt you?	Never (1) Rarely (2) Sometimes (3)	Fairly often (4) Frequently (5)
10. How often does anyone, including family and friends, insult or talk down to you?	Never (1) Rarely (2) Sometimes (3)	Fairly often (4) Frequently (5)
11. How often does anyone, including family and friends, threaten you with harm?	Never (1) Rarely (2) Sometimes (3)	Fairly often (4) Frequently (5)
12. How often does anyone, including family and friends, scream or curse at you?	Never (1) Rarely (2) Sometimes (3)	Fairly often (4) Frequently (5)