

PEDIATRIC INITIAL HEALTH ASSESSMENT

Name of Child	ID Number	Date of Birth
Last Well Child/Adolescent Exam	Date Medical History Obtained	Medical History Source
Nationality		

BIRTH HISTORY

State, Country where child was born		Pregnancy/Delivery problems	
Delivery type		Postpartum Complications	
Was baby discharged with mother? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, why?	
Birth weight:	lbs.	oz.	Apgar
			Length of baby's hospital stay
Results of hospital nursery hearing screening:			

IMMUNIZATION HISTORY

Immunization record obtained: <input type="checkbox"/> Yes <input type="checkbox"/> No			Immunizations current: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of last PPD:			Results:		
DTaP	#1	#2	#3	Booster	Booster
IPV	#1	#2	#3	Booster	
HIB	#1	#2	#3	#4	
MMR	#1	#2			
HepB	#1	#2	#3		
Varicella *	#1				
Pneumococcal	#1	#2	#3	#4	
Influenza					
Hepatitis A					
Meningococcal					
Rotavirus	#1	#2	#3		
HPV	#1	#2	#3		

* Please document date or age child may have had chicken pox (below) if no vaccine given.

MEDICAL HISTORY

Allergies to Food, Environment or Medications	
Hospitalizations	
Surgeries	
Injuries/Accidents	
Significant Illnesses	
Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, method of contraception:
Sexually Transmitted Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:

CHILD HAS HAD

- Chicken pox date and/or age: _____ Mumps date: _____
 Measles date: _____ TB date: _____
 Any other problems _____

PRESENT MEDICATIONS

Prescription	OTC

LAB TESTS (if applicable)

- Blood lead test date: _____ Newborn Metabolic Screen date: _____
 Blood hgb/hct date: _____ Urinalysis date: _____
 Cholesterol date: _____ Pap test date: _____

FAMILY MEDICAL HISTORY

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Obesity
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Seizures
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sickle Cell Disease/Trait
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Deafness	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Other		

SOCIAL/CULTURAL HISTORY

School name		Grade level	
Language spoken at home		Number of family members living in the same house	
Primary caretaker of the child			
	Name	Occupation	Age
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			

ENVIRONMENTAL HISTORY

- Alcohol use Yes No
 Drug use Yes No
 Tobacco use Yes No
 Exposure to tobacco smoke Yes No

PROVIDER COMMENTS:

SIGNATURE OF PROVIDER WHO OBTAINED/REVIEWED HISTORY

DATE