Mattel Children's Hospital UCLA

PEDIATRIC HEALTH HISTORY

Name:_____ Today's Date: _____

Age: _____ Birth date: _____ Pediatrician / Referring Physician:_____

What is the reason for your visit? _____

_____

PAST MEDICAL HISTORY

Please list any hospitalizations, operations, serious illnesses or accidents (with dates).

_____

_____

BIRTH HISTORY (for children under 5 years of age)

Regular Prenatal Care ☐ Yes ☐ No Birth weight _____

Term of Pregnancy ☐ Full Term ☐ Premature Late Term

Type of delivery ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Breech ☐ Induced

Please list birth complications, if any.

_____

_____

How long did the child stay in the hospital, after birth? _____

Are the child's immunizations up to date? ☐ Yes ☐ No Child's grade in school: _____

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

check ☒ if your blood relatives had any of the following:

Disease	Relationship to you
☐ Heart Disease	
☐ Tuberculosis	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Allergies/Asthma	
☐ Cancer	
☐ Diabetes	
☐ Mental/Emotional problems	
☐ Sickle Cell	
☐ Seizures	

MEDICATIONS List medications you are currently taking

ALLERGIES to medications or substances

Symptoms: check ☒ symptoms you currently have, or have had in the past year

CONSTITUTIONAL
- ☐ Fever
- ☐ Night sweats
- ☐ Chills
- ☐ Loss of weight
- ☐ Gain in weight
- ☐ Weakness

SKIN
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Dryness
- ☐ Birthmarks

Breast
- ☐ Lumps
- ☐ Swelling
- ☐ Tenderness

EYES
- ☐ Eye infections
- ☐ Visual changes
- ☐ Crossed eyes

ENMT
- ☐ Ear infections
- ☐ Difficulty hearing
- ☐ Nosebleed
- ☐ Snoring
- ☐ Sinus problems
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Mouth breathing

ENDOCRINE
- ☐ Thyroid enlargement
- ☐ Heat/Cold intolerance

RESPIRATORY
- ☐ Wheezing
- ☐ Persistent Cough
- ☐ Shortness of breath
- ☐ Other: _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Difficulty Breathing
- ☐ Rapid Heart Beat
- ☐ Swelling of arms/legs
- ☐ Swelling of whole body
- ☐ Pale or blue lips/skin

HEME / LYMPH
- ☐ Swollen glands
- ☐ Anemia
- ☐ Sickle cell anemia
- ☐ Easy bruising

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Difficulty Swallowing
- ☐ Hemorrhoids
- ☐ Rectal Bleeding
- ☐ Vomiting Blood
- ☐ Yellow Skin/Eyes
- ☐ Lack of stool control
- ☐ Other: _____

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Lack of bladder control
- ☐ Bulging in groin

Female
- ☐ Vaginal discharge
- ☐ Menstrual pain
- ☐ Bleeding bet. periods

Date of last menstrual period: _____

Date of last pap smear: _____

Genito-Urinary (cont...)

Male
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

NEURO
- ☐ Headache
- ☐ Convulsions
- ☐ Paralysis
- ☐ Numbness

MUSCULO-SKELETAL
- ☐ Pain or swelling in muscles/joints
- ☐ Muscle weakness
- ☐ Broken bones
- ☐ Bow legs
- ☐ Club foot

IMMUNO/ALLERGIC
- ☐ Persistent infections
- ☐ HIV exposure
- ☐ Food Allergies: _____

PSYCH
- ☐ Nervousness
- ☐ Depression
- ☐ Hyperactivity
- ☐ Behavioral problems

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____
Parent or Guardian Signature Date Time

_____ _____ _____
Reviewed By Print Name Signature Date Time