Little House PEDIATRICS
8734 Lee Vista Blvd. Suite 400 Orlando, FL 32829
Tel:(407) 910-2340 Fax: (407) 237-0944

Health History Form

Patient Name DOB: Date:

BIRTH HISTORY: (circle one or explain)		**MEDICATIONS**	
Where was your child born? (Hospital name or city)		Taking any medications?(includes Vit, OTC ,prescriptions)	Yes No
What was his or her birth weight?		**ALLERGIES**	
Was he/she full term? If not how many weeks early or late was he/she?	Yes No	Allergic to any medications? If yes, what med and what reaction?	Yes No
Were there any complications during pregnancy? If yes, explain	Yes No	Allergic to any foods? If yes, what foods	Yes No
Was the delivery of your child? Vaginal C-Section		Allergic to anything in the environment	Yes No
Were there any complications during delivery? If yes, explain	Yes No	**HOSPITALIZATIONS**	
Was the baby in NICU? If yes, how long and why?	Yes No	Was your child ever admitted to the hospital overnight? If so, when	Yes No
Did the baby required phototherapy for jaundice?	Yes No	Have you ever taken your child to the emergency room? If yes, what for	Yes No

SURGICAL HISTORY – Has your child ever had surgery? If yes, please indicate type of surgery, hospital and dates

PAST MEDICAL HISTORY – If there is no past medical history check here O otherwise circle if your child has or has had any medical problems

Chronic illness	Yes No	School problems	Yes No	Sickle cell	Yes No
Broken bones	Yes No	Seizures	Yes No	Diabetes	Yes No
Ear infections	Yes No	Urinary tract infections	Yes No	Thyroid problems	Yes No
Pneumonias	Yes No	Bleeding problem	Yes No	Chicken Pox	Yes No
Asthma	Yes No	Heart murmur	Yes No	Wears glasses	Yes No
ADHD	Yes No	Cystic Fibrosis	Yes No	Other:	

FAMILY HISTORY – If there is no family history check here O otherwise indicate by checking in the circle below

Heart Disease O	Asthma O	Crohn's Disease O	Psychiatric Disorder O	Allergies O
High Blood Pressure O	Emphysema O	Bleeding Disorder O	ADD/ADHD O	Immune defect O
High Cholesterol O	Cystic Fibrosis O	HIV infection O	Birth Defects O	Adopted O
Diabetes O	Tuberculosis O	Arthritis O	Kidney Disease O	Foster Child O
Cancer O	Hepatitis O	Seizure Disorder O	Neurologic Disorder O	No history available O
Thyroid Disease O	Ulcerative Colitis O	Stroke O	Alcohol/drug abuse O	Other O

SOCIAL BACKGROUND

Child lives with (circle one)	Both parents	Mother	Father	Guardian/other
Child lives in (circle one)	House	Apartment/Condo		
Pets at Home (circle one)	Dog (s)	Cat(s)	Bird(s)	Fish
	Turtle/Lizard	Other		

SMOKING : Does anyone smoke inside or outside the house? Yes No

ETHNIC BACKGROUND Caucasian Hispanic African American Asian American Indian Other

NATIVE LANGUAGE English Spanish Creole Other

FOR PATIENTS 13 AND OLDER

History of Drug Use	Yes No	History of Alcohol Use	Yes No	History of Tobacco Use	Yes No

Please describe any other problems with your child where we may be able to help