FAMILY CARE
410 Genesis, Suite-C Webster, TX 77598

Pediatric Health History Form – Initial Visit

Child's Name: ______________________ Date of Birth: ____________ Age: ________

Parent Name: ______________________ Relationshipto Child: ______________

How did you hear about us? ______________________

Child's Past Medical History:

Where was your child born? ______________________

Pregnancy/Neonatal Period

Is the child yours by: ☐ birth ☐ adoption ☐ stepchild ☐ other: ____________

Pregnancy complications: ______________________

Delivery by: ☐ vaginal ☐ c-section Reason for c-section: ____________

Complications: ______________________

Was your child premature ☐ No ☐ Yes, born at ____ weeks Complications: ____________

Apgar scores 1 minute: ________ 5 minutes: ________ Birth weight: ________ Length: ________

Other problems in the newborn period: ______________________

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

☐ 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 bones: ____________

☐ Mental retardation or learning disability: ____________

☐ Depression/anxiety: ____________

☐ Other chronic medical conditions: ____________

Has your child ever been hospitalized ☐ No ☐ Yes (explain) ______________________

Previous surgeries and dates: ______________________

____

Please list any specialist your child is currently seeing and reason: ______________________

Medications:

ALLERGIES to medicine/vaccines (list and describe reaction): ______________________

____

Current medications and doses: ______________________

____

Vitamins: ____________ Herbal supplements: ____________ Over-the- counter meds: ____________

Pharmacy Information:

Pharmacy Name: ______________________ Phone: ____________

PharmacyAddress: ______________________

Development/Nutrition's

At what age did your child:

Sit alone: ________ Walk alone: ________ Say Words: ________ Toilet Train: ________ 1st periods (females): ________

Was your child breastfed

☐ No

☐ Yes, how long? ________

Current milk intake: Type: ______ Amount: ______ OZ

Has your child had any unusual feeding/dietary problems? (explain)

____

Social History

Who lives in the household with the child?
☐ Mom ☐ Dad ☐ Siblings (# ____) ☐ Grandparents ☐ Other

Child's parents are: ☐ Married ☐ Unmarried ☐ Divorced ☐ Other

Childcare: ☐ Parents ☐ Relatives ☐ Daycare ☐ Babysitter/Nanny

Days per week in childcare (not with parents): ______________________________

Do any household members smoke? ☐ Yes ☐ No

How many hours per day does your child spend? Watching TV ______ Video games ______ Computer ______

Child's school name: ______________________________ Grade: ________

Any concerns about school performance? ☐ No ☐ Yes (explain) ______________________________

Any concerns about peer or teacher relationships? ☐ No ☐ Yes (explain) ______________________________

Sports/exercises: Type ______________ How often? __________ How long? _____ min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma				
Anemia				
Blood disorder				
Cancer				
Heart				
attack/disease				
Cholesterol High				
High blood pressure				
Stroke				
Diabetes				
Thyroid disease				
Kidney disease				
Seizures				
Migraines				
Depressions/anxiety				
Alcoholism				
ADD/ADHD				

Please explain all positive: ____

Review of Systems (all that apply)

→ Constitutional

- [ ] Fever, chills
- [ ] Fatigue
- [ ] Unexplained weight loss/gain
- [ ] Excessive Thirst

→ Ear, Nose, and Throat

- [ ] Loud voice, hearing problem
- [ ] Mouth-breathing, snoring
- [ ] Ear pain
- [ ] Frequent runny nose

→ Respiratory

- [ ] Cough, short of breath
- [ ] Chest tightness, wheeze

→ Musculoskeletal

- [ ] Muscle pain, weakness
- [ ] Joint pain, swelling
- [ ] Bone pain

→ Gastrointestinal

- [ ] Nausea, vomiting, diarrhea
- [ ] Constipation
- [ ] Abdominal Pain

→ Cardiovascular

- [ ] Chest pain, palpitations
- [ ] Tired easily on exertion
- [ ] Fainting

→ Genitourinary

- [ ] Frequent or painful urination
- [ ] Bedwetting, frequent accidents
- [ ] Vaginal or penis discharge

→ Neurologic

- [ ] Headaches
- [ ] Seizures
- [ ] Clumsiness
- [ ] Milestone delay

→ Psychiatric/Emotional

- [ ] Anxiety/stress
- [ ] Depression
- [ ] Sleep problems
- [ ] Anger concern
- [ ] Concern with attention, impulsivity

Vaccines:

Vaccine	Date Given	Date Given	Date Given	Date Given
DTaP/Tdap				
Polio (IPV)				
MMR				
Varicella				
Hepatitis B				
Hepatitis A				
Hib				
PCV (Pneumococcal)				
Meningococcal				
Influenza (Flu)				
HPV				
COVID-19				
Other:				

Reviewed by: ______________________________ Date:June 5, 2026 (Updated)