Express Care Clinic/West Lincoln Family Medicine
201 Capitol Beach Boulevard, Suite 1A
Lincoln, NE 68528

Pediatric Health History

Name: _____ Date: _____

Sex: M F Age: _____ DOB: _____

_____

Mother's Name *Home Phone:* *Work Phone:*

_____

Father's Name *Home Phone:* *Work Phone:*

Current Medical Problem: _____

_____

_____

Past History:

Birth Weight: _____ Birth Length: _____

Pregnancy: Any problems during this child's pregnancy (bleeding, infection)?

_____

_____

Labor: Any problems during this child's labor (breech, baby's heart rate slow)?

_____

_____

Delivery: Any problems during this child's delivery (c-section, forceps, late)?

_____

_____

Hospital: Any problems during this child's hospital stay (jaundice, infections)?

_____

_____

Allergies: Is this child allergic to Penicillin? Yes No
Is this child allergic to Sulfa? Yes No

Other Allergies: _____

Surgeries: List any surgeries this child has had and dates performed: _____

_____

Other Hospitalizations and illnesses: _____

_____

Medications: _____

Immunization: *(please give dates or provide a copy of previous immunization record)*

DTP:	1st	2nd	3rd	4th	5th
Polio:	1st	2nd	3rd	4th	5th

Measles, Mumps Rubella (MMR): _____
Hepatits B: _____
HIB: _____
Tetramune (DTP & H flu B): _____
Pneumovax: _____
Td: _____

Pediatric Health History

Name: _____ Date: _____

Has this child had any of the following problems: *(Include both recent past and present)*

GENERAL

Anemia	Yes	No
Recent Weight Change	Yes	No
Thyroid Problems	Yes	No
Diabetes/High Blood Sugar	Yes	No
Frequent Fever or Chills	Yes	No
Frequent Large Lymph Glands	Yes	No
Other	Yes	No

SKIN

Frequent Rashes	Yes	No
Changing Mole	Yes	No
Other	Yes	No

HEAD

Frequent Headaches	Yes	No
Visual Problem Not Corrected by Glasses	Yes	No
Glaucoma	Yes	No
Frequent Dizziness	Yes	No
Fainting	Yes	No
Epilepsy or Seizures	Yes	No
Weakness in Arms or Legs	Yes	No
Numbness	Yes	No
Frequent Ear Infections	Yes	No
Hearing Difficulties	Yes	No
Ringing in Ears	Yes	No
Frequent Nosebleeds	Yes	No
Frequent Nasal Congestion	Yes	No
Difficulty Swallowing	Yes	No
Persistent Hoarseness	Yes	No
Other	Yes	No

LUNGS

Severe Shortness of Breath	Yes	No
Asthma or Emphysema	Yes	No
Frequent Cough	Yes	No
Coughing Up Blood	Yes	No
Tuberculosis	Yes	No
Other	Yes	No

HEART

High Blood Pressure		
Rheumatic Fever	Yes	No
Chest Pain of Pressure	Yes	No
Irregular Heartbeat	Yes	No
Other	Yes	No

DIGESTIVE TRACT

Indigestion or Hearburn	Yes	No
Ulcers	Yes	No
Frequent Abdominal Pain	Yes	No
Vomiting Blood	Yes	No
Hepatitis or Liver Problems	Yes	No
Gallbladder Problems	Yes	No
Frequent Diarrhea	Yes	No
Hemorrhoids	Yes	No
Rectal Bleeding	Yes	No
Black Tarry Bowel Movements	Yes	No
Recent Change in Bowel Habits	Yes	No
Other	Yes	No

URINARY

Bladder or Kidney Infection	Yes	No
Kidney Stones	Yes	No
Burning with Urination	Yes	No
Difficulty Passine Urine	Yes	No
Difficulty Controlling Urine	Yes	No
Getting Up at Night to Urinate	Yes	No
Blood in Urine	Yes	No
Other		

GENITALIA

Undescended Testes

BEHAVIOR

School Problems
Sleep Difficulty
Nightmare/terrors
Unusual Fears
Problems Playing with Other Children
Poor Appetite
Temper Tantrums

DEVELOPMENT

Age child…

Sat Up Alone: _____
Crawled: _____
Walked: _____
Talked in Phrases: _____