FOX RIVER PEDIATRICS HEALTH HISTORY FORM

Date: _____

Child Name: _____

Date of Birth: _____

_____ Adopted _____ Biological

Place of Birth: _____

Obstetrician Name:_____

Mother's Age at time of Delivery: _____

Method of Delivery (Check all that apply):

- ☐ Vaginal Delivery
- ☐ Induced
- ☐ Prolonged
- ☐ Breech
- ☐ C- Section
- ☐ Full Term
- ☐ Premature _____ weeks gestation
- ☐ Post Term/Late

Pre-natal care received?

_____ Yes _____ No

Was tobacco used during pregnancy?

_____Yes _____No

Was alcohol consumed during the pregnancy?

_____ Yes _____ No

Previous Physician Name: _____

Practice Name: _____

City: _____ State: _____

LIST DATES/REASON FOR ALL HOSPITALIZATIONS/INURIES/BLOOD TRANSFUSIONS:

_____

_____

_____

_____

_____

_____

LIST CURRENT MEDICATIONS THE CHILD IS TAKING:

Name of Medication Dosage Frequency

_____

_____

_____

_____

FOOD ALLERGIES:

Allergies: _____

Medication Allergies: _____

Immunization Allergies: _____

The child's immunizations are:

- ☐ Current
- ☐ Behind
- ☐ Not Sure

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Child's General Health during Infancy:

- ☐ Satisfactory
- ☐ Unsatisfactory

DEVELOPMENTAL HISTORY

- ☐ Milestones consistent with age.
- ☐ Delayed milestones.
- ☐ Not sure.

PARENTAL CONCERNS:

_____

_____

_____

_____

FAMILY HISTORY

Father Name: _____ Age: _____

General Health: _____

Mother Name: _____ Age: _____

General Health: _____

Paternal Grandfather Name: _____ Age: _____

General Health: _____

Paternal Grandmother Name: _____ Age: _____

General Health: _____

Maternal Grandfather Name: _____ Age: _____

General Health: _____

Maternal Grandmother Name: _____ Age: _____

General Health: _____

Siblings	Age	General Health
1.		
2.		
3.		
4.		
5.		
6.		

DCFS Involvement in the past?

_____ Yes _____ No

_____

Parent/Guardian Signature Date

_____

Physician/Nurse Practitioner Signature Date