

French Broad Pediatrics
 40 N Merrimon Ave. Suite 117
 Asheville, NC 28805
 Pediatric Health History Form -Initial Visit

Child's Name _____
 Your Name _____
 Previous Physician/Specialist with dates and reason _____

Preferred Pharmacy _____
 Reason for today's visit _____

Current Medications/Vitamins/Supplements
 (name) (dose)

Allergies No Known Yes
 (name and type of reaction)

Immunizations/Vaccines
 Please list previous vaccines and most recent flu vaccine _____

 Concerns regarding immunizations _____

Birth History
 Jaundice? No Yes _____
 Infection? No Yes _____
 Breathing? No Yes _____
 Low Blood Sugar? No Yes _____
 Oxygen Use? No Yes _____
 NICU stay? No Yes _____
 Was your child premature? No Yes _____
 Delivery? vaginal c-section breech
 Where was your child born? _____

Birth weight? _____ Length _____
 Other problems in the newborn period? _____

Past Medical History
Infancy/Childhood/Adolescence
 Has your child ever been treated or diagnosed with:
 (explain)
 Asthma or reactive airway disease _____
 Wheezing or bronchitis _____
 Recurring strep throat _____
 Seasonal Allergies _____
 Eczema _____

Pneumonia _____
 Urinary Tract Infections _____
 Seizures _____
 Anemia _____
 Broken Bones _____
 Depression/Anxiety _____
 ADHD/ADD _____
 Heart Murmur _____
 Constipation _____
 Bedwetting/Incontinence _____
 Other chronic medical conditions _____

Has your child ever been hospitalized? No Yes
 (explain) _____

Previous Surgeries and dates _____

Family History (Mother, Father, Sibling, Grandparent)
 Please list family members diagnosed with any chronic medical condition _____

Social History
 Diet: regular vegetarian gluten free diabetic
 Caffeine: rarely moderate often
 List any sporting activities _____

Who lives in the child's home? Mom Dad
 Step-parent Siblings(# ___)
 Other _____
 Child's parents are married unmarried
 divorced other _____
 Childcare parents daycare/after school
 babysitter/nanny
 Any pets? no yes How many ___ type _____

Do any household members smoke? No Yes
 Are their smoke detectors in the home? No Yes
 Does your child use a seatbelt, car seat, carrier? No Yes
 Are there guns present in the home? No Yes
 Year in School _____
 School Name _____

Does your child have fluoride in their drinking water?
 No Yes
 Please review the topics listed below. Check if you any concern about your child:
 Physical Problem
 Vision
 Development
 Sleep Pattern
 Diet/Weight/Nutrition
 Emotional Development