LAURELWOOD pediatrics

Family Health History

Today's Date:

♦Dr. Lana Yanishevski ♦ Dr. Chris Hanson ♦ Dr. Ashley Miller ♦ Dr. Joel Siegel ♦ Dr. Nouth Magdovitz

Please complete this page once for your entire family

Please list all household members:

NAME	DATE OF BIRTH

If mother and father are not living together, what is the child's/children's custody status?

_____

Family History – Please put a check in any of the boxes and explain further below

	Father	Mother	Father's Parents	Mother's Parents	Brother or Sister		Father	Mother	Father's Parents	Mother's Parents	Brother or Sister
Cancer						Kidney Disease					
Diabetes						Glaucoma					
Heart Disease						Bleeding Disorders					
Stroke						Mental Illness					
High Blood Pressure						Mental Retardation					
Immune Problems						Epilepsy/ Seizures					
Other:						Other:					

Explanation of any positive answers above: _____

_____

_____

_____

LAURELWOOD pediatrics

Initial Health Questionnaire

Today's Date:

♦Dr. Lana Yanishevski ♦ Dr. Chris Hanson ♦ Dr. Ashley Miller ♦ Dr. Joel Siegel ♦ Dr. Nouth Magdovitz

Child's Name: _____ Date of Birth: _____

Birth History – **Only complete this section if child is under 18 months**			
Birth Weight:	Birth Length:		
☐ Premature? (less than 36 weeks) Yes / No -If yes, how many weeks early? _____ ☐ Pregnancy Complications? Yes / No ☐ Delivery Complications? Yes / No ☐ C-section? Yes / No Please explain: _____		Initial feeding: Breast / Bottle -If bottle, which type of formula? _____ Does your child attend day care? Yes / No	
During pregnancy, did mother: ☐ Smoke? Yes / No ☐ Drink alcohol? Yes / No ☐ Use drugs or medications? Yes / No Please explain: _____			

General History - Please explain any "Yes" answers below

- Do you have any concerns regarding your child's health? ☐ Yes ☐ No
- Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No
- Has your child had any serious injuries or accidents? ☐ Yes ☐ No
- Has your child had any surgery? ☐ Yes ☐ No
- Has your child ever been hospitalized? ☐ Yes ☐ No
- Has your child ever seen any specialists? ☐ Yes ☐ No
- Is your child allergic to any medications or drugs? ☐ Yes ☐ No

Please explain: _____

_____

_____

Child's Name: _____ Date of Birth: _____

General Development - Please explain any "Yes" answers below

- Are you concerned about your child's physical development? ☐ Yes ☐ No
- Are you concerned about your child's mental/emotional development? ☐ Yes ☐ No
- Are you concerned about your child's attention span? ☐ Yes ☐ No

If your child is in school:

- Are you concerned about your child's behavior in school? ☐ Yes ☐ No
- Has your child had any serious academic problems? ☐ Yes ☐ No
- Is your child in any resource classes? ☐ Yes ☐ No

Please explain: _____

_____

_____

Medical History- Please answer every question

	YES	NO	EXPLAIN ANY "YES" ANSWERS
Child ever had chickenpox?			
Frequent ear infections?			
Problems with ears or hearing?			
Nasal allergies?			
Chronic or frequent colds?			
Problems with eyes or vision?			
Asthma, bronchitis, bronchiolitis, or pneumonia?			
Any heart problem or murmur?			
Palpitations (pounding heart)?			
Anemia or bleeding problem?			
Blood transfusion?			
Frequent abdominal pain?			
Constipation requiring doctor visits?			
Bladder or kidney infections?			
Blood in urine?			
Bedwetting (after 5 years old)?			
Sleepwalking?			
Any chronic or recurrent skin problems (acne, eczema, etc.)?			
Frequent headaches?			
Head injury?			
Seizures or other neurological problems?			
Diabetes?			
Thyroid or endocrine problems?			
(Females only) Has she started her periods?			If yes, at what age was her first period? ____
(Females only) Any problems with her periods?			