HALEIWA FAMILY HEALTH CENTER
PEDIATRIC HEALTH HISTORY
Age 0-3 Years Old

Date_____

NAME_____SEX_____ BIRTH DATE__/__/__
PREVIOUS MEDICAL CARE_____ PLACE OF BIRTH_____
(Clinic's/Doctor's name)

PREGNANCY AND BIRTH HISTORY

Length of Pregnancy_____months. Prenatal care_____months.
Medications during pregnancy?_____
Any problems with pregnancy?_____
Type of delivery (circle): Vaginal Forceps Caesarean section Breech
Transfusion?:_____
Any problems?:_____
Days in hospital: Mother_____Baby_____
Baby's birth weight_____Apgars (if known)_____
Did baby have any problems after birth? (circle)
Breathing trouble Blue Transfusion Feeding problem Jaundice
Birth defect Seizures Infection Other_____

DEVELOPMENAL HISTORY

Age at which child: Rolled over_____Walked_____
Stood alone_____Was toilet trained_____
Sat alone_____Spoke words_____
Any problems with development?_____

List any allergies to medication, food, plants, insects:_____

Is your child taking ? (circle) Vitamins Flouride Iron
Is your child's appetite? Good Fair Poor
Circle those foods eaten daily?
Milk Products Cereal Fruits Vegetables Breast milk
Meat or fish Sweets Soda Formula Cow's milk

FAMILY HISTORY

Circle if present in close family:
Diabetes High blood pressure Heart Disease Cancer Gout
Tuberculosis Allergy Asthma Kidney Disease Glaucoma
Epilepsy Anemia Bleeding problem

Father's age_____ Health_____If deceased, age & cause of death:_____
Mother's age_____ Health_____If deceased, age & cause of death:_____
Number of other children in family?_____List their ages:_____
Any health problems?_____

Please give your child's immunization record to the nurse.