

HALEIWA FAMILY HEALTH CENTER
PEDIATRIC HEALTH HISTORY
Age 3-10 Years Old

Date _____

NAME _____ SEX _____ BIRTH DATE _____
PREVIOUS MEDICAL CARE _____ PLACE OF BIRTH _____
(Clinic's /Doctor's name)

CURRENT HEALTH

Circle those words that apply to your child:

Healthy Sick Pale Tired Rash Congested Ear Trouble Bad Teeth Eye Trouble
Speech problem Poor Appetite Worms Diarrhea Constipation Urine problem
Bed wetting Trouble walking Hyperactive Nervous Good child Sleeps poorly
Happy Fussy Hard to manage Spoiled Temper tantrums School problems
Jealous Bad dreams Skinny Fat Doesn't get along with others

Is your child taking medications? _____

Child's grade in school _____ Any school problems? _____

Who else lives at home? _____

Any home, family or marriage problems? _____

Any behavior problems? _____

What are your child's special abilities or talents?

What is the main reason for your child's visit today? _____

Any other things you would like to talk about? _____

MEDICAL HISTORY

List any illnesses or hospitalizations and give date(or age): _____

List any surgeries: _____

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

FAMILY HISTORY

Circle if present in close family::

Diabetes High blood pressure Heart Disease Cancer Tuberculosis Gout Allergy
Asthma Kidney disease Glaucoma Epilepsy Anemia Bleeding problems

Father's age _____ Health _____ If deceased, age & cause of death _____

Mother's age _____ Health _____ If deceased, age & cause of death _____

Number of children in family? _____ List their ages _____

Any health problems? _____

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