NJ Craniofacial Center

Health History – Pediatric
Confidential

Name of Patient:_____DOB:_____

PRIMARY CONCERN: _____

General: [ ] Fever [ ] Chills [ ] Sweats [ ] Anorexia
[ ] Weight Loss [ ] Fatigue [ ] Obesity [ ] Difficulty Sleeping

Eyes: [ ] Blurring [ ] Irritation [ ] Cross-Eyed [ ] Vision Loss
[ ] Eye Pain [ ] Light Sensitivity [ ] Double Vision
[ ] Glasses/Contacts [ ] Drainage/Discharge

Ears/Nose/Throat: [ ] Earaches [ ] Ear Infections [ ] Ringing in ears
[ ] Decreased Hearing [ ] Nasal Congestion [ ] Nose Bleeds
[ ] Sore Throat [ ] Hoarseness [ ] Swallowing Problems
[ ] Drooling

Cardiovascular: [ ] Chest Pain [ ] Palpitations [ ] Fainting
[ ] Shortness of Breath [ ] Leg Swelling [ ] Heart Murmur
[ ] Discoloration of extremities

Respiratory: [ ] Cough [ ] Shortness of Breath [ ] Excessive Sputum
[ ] Coughing of Blood [ ] Wheezing
[ ] Difficulty Breathing [ ] Other_____

Gastrointestinal: [ ] Nausea [ ] Vomiting [ ] Diarrhea [ ] Constipation
[ ] Change of Bowel Habits [ ] Blood in Stool
[ ] Abdominal Pain [ ] Jaundice [ ] Other_____
[ ] Decrease Appetite [ ] Feeding/Eating Problems
[ ] Breast/Bottle Feed [ ] Special Diet_____

Genitourinary [ ] Pain on Voiding [ ] Blood in Urine [ ] Discharge
[ ] Urinary Frequency [ ] Urinary Hesitation
[ ] Incontinence [ ] Bed Wetting
[ ] Awakening at night to void [ ] Intermittent Catherization

Musculoskeletal: [ ] Back Pain [ ] Joint Pain [ ] Joint Swelling
[ ] Muscle Cramp [ ] Muscle Weakness [ ] Rigidity
[ ] Stiffness [ ] Arthritis [ ] Spasticity
[ ] Coordination/Motor Delay [ ]Decreased Strength
[ ] Right/Left Handed

Skin: **[ ] Rash** **[ ] Itching** **[ ] Dryness**
[ ] Birth Marks

Neurologic: **[ ] Temporary Paralysis** **[ ] Weakness** **[ ] Numbness**
[ ] Seizures **[ ] Tremors** **[ ] Dizziness** **[ ] Fainting**
[ ] Confusion **[ ] Hyperactivity** **[ ] Lethargy**
[ ] Difficulty Supporting Head
[ ] Difficulty Concentrating **[ ] Language Delay** **[ ] Headaches**
[ ] Location of Headache_____

Psychiatric: **[ ] Depression** **[ ] Anxiety** **[ ] Memory Loss** **[ ] Paranoia**
[ ] Mental Disturbance **[ ] Suicidal Ideations** **[ ] Hallucination**
[ ] Low Self Esteem **[ ] Poor Decision Making** **[ ] Socially Isolated**

Endocrine: **[ ] Cold intolerance** **[ ] Heat intolerance** **[ ] Increased appetite**
[ ] Increased urination **[ ] Increased thirst** **[ ] Weight changes**
[ ] Delayed or Early Puberty

Heme/Lymphatic: **[ ] Abnormal bruising** **[ ] Bleeding**
[ ] Enlarged lymph nodes **[ ] Frequent Infections**
[ ] Other_____

Allergic/Immunologic: **[ ] Seasonal Allergies** **[ ] Persistent Infections**
[ ] HIV Exposure **[ ] Other _____**

GIRLS/WOMEN:
Age you began Menstrual Period _____

Family History

Please check and circle **ONLY** those that Apply

[ ] Heart Disease	**Mother**	**Father**	**Sibling**	**Grandparent**
[ ] Hypertension	**Mother**	**Father**	**Sibling**	**Grandparent**
[ ] Diabetes	**Mother**	**Father**	**Sibling**	**Grandparent**
[ ] Cancer	**Mother**	**Father**	**Sibling**	**Grandparent**
[ ] Stroke	**Mother**	**Father**	**Sibling**	**Grandparent**
[ ] Hyperlipidemia (High cholesterol)	**Mother**	**Father**	**Sibling**	**Grandparent**
[ ] Hematologic (Bleeding)	**Mother**	**Father**	**Sibling**	**Grandparent**

Patient's Social History

Siblings Names and Ages: _____

Siblings Names and Ages: _____

Siblings Names and Ages: _____

School Name and Grade of Patient: _____

Daycare Name: _____

Hobbies & Sports: _____

Handedness: [ ] Right [ ] Left [ ] Ambidextrous

Does child attend any therapy?

[ ] Physical Therapy [ ] Occupational Therapy [ ] Speech Therapy [ ] EIP

Place of Birth (Hospital):_____

Complications during pregnancy? _____

Was there birth trauma or a difficult delivery? _____

Birth: Born _____Weeks [ ] vaginally [ ] C-Section

Parent's Marital Status: [ ] Married [ ] Divorced [ ] Single [ ] Separated

Additional Information: _____

Medications & Dosage **All current medications including ASPIRIN & Vitamins**	**Allergies** **Please include FOOD and LATEX**

Conditions

Please check **ONLY** those that apply

[ ] ADHD
[ ] AIDS
[ ] Abnormal Head Shape
[ ] Anemia
[ ] Anorexia
[ ] Allergic Rhinitis
[ ] Arthritis
[ ] Asthma
[ ] Bipolar disorder
[ ] Bleeding Disorders
[ ] Bronchitis
[ ] Bulimia
[ ] Cancer
[ ] Cataract
[ ] Cerebral Palsy
[ ] Chemical Dependency
[ ] Chicken Pox
[ ] Childhood Diseases
[ ] Cleft Lip/Palate
[ ] Croup
[ ] Down syndrome
[ ] Epilepsy
[ ] Glaucoma
[ ] G Tube
[ ] Gastric Reflux
[ ] Head Injury
[ ] Hernia
[ ] Heart Disease
[ ] Hepatitis
[ ] Herpes
[ ] High Cholesterol
[ ] HIV Positive
[ ] Hydrocephalus
[ ] Kidney Disease
[ ] Migraine Headaches
[ ] Measles
[ ] Multiple Sclerosis
[ ] Mumps
[ ] Pacemaker
[ ] Pneumonia
[ ] Psychiatric Care
[ ] Rheumatic Fever
[ ] Rubella
[ ] Scarlet Fever
[ ] Scoliosis
[ ] Shunt
[ ] Spina Bifida
[ ] Stroke
[ ] Suicide Attempts
[ ] Thyroid Problems
[ ] Tonsillitis
[ ] Tourette (Tic) Disorder
[ ] Tuberculosis
[ ] Ulcers
[ ] Urinary Tract
[ ] Infection

Are Immunizations Up to Date? YES NO

Height_____ **Weight_____**