Greeley County Health Services

Serve with Compassion & Excellence

PEDIATRIC HEALTH HISTORY FORM (AGE 18 AND UNDER)

Please complete this form to add to your health records.

Today's Date:_____

Patient Name: _____Date of Birth: _____
(as appears on insurance card first, middle, and last)

Parent / Guardian: _____ Date of Birth: _____

2nd Parent / Guardian: _____ Date of Birth: _____

Previous doctor: □ None □ Yes (name)_____ Date Last seen:_____

Dentist:_____ Date Last seen:_____Eye Doctor:_____ Date Last seen:_____

Specialist:_____Date Last seen:_____
(Name and Specialty)

Specialist:_____Date Last seen:_____
(Name and Specialty)

Specialist:_____Date Last seen:_____

<u>*Please provide copy of updated immunization record</u>.**

<u>Social History</u>

Tobacco_____a day Number of years_____ Year quit_____

Vaping _____a day Number of years_____ Year quit_____

Alcohol_____ drinks per day/week Caffeine_____ drinks per day

Street drugs_____

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MEDICAL HISTORY: Please circle all that apply

General	Chills Fatigue Fever Night Sweats Sleep Difficulties
Neck	Neck Mass Neck Pain Swollen Glands
Female Genitourinary	Pelvic Pain Urinary complaints Vaginal bleeding problem Vaginal Discharge
Breast health	Breast pain Breast lump Nipple Discharge
Behavioral	Anxiety Depression Mood swings Change in sleep patterns Appetite Changes Change in family relationships
Respiratory	Coughing up blood Shortness of breath Wheezing
Endocrine	Weight gain Excessive Thirst Weight loss Hot flashes
Male Genitourinary	Blood in urine Erectile dysfunction
Hematology	Bruising Anemia Blood transfusion Changes in moles Blood clots

Chronic medical problems *(circle all that apply)*

High Blood Pressure Asthma Heart Attack Heart Disease Emphysema/Lung Disease COPD Diabetes Kidney Problems Stroke Cancer High Cholesterol Thyroid Glaucoma	
Other	

Surgeries

Year	Reason	Hospital / Clinician

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Family history: **(if any blood relative has suffered from the following conditions, please mark, and indicate below which relative, i.e Maternal/Paternal Grandmother or Grandfather, aunt or uncle.)**

____ **High blood pressure** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Asthma** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Heart Attack** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Emphysema/Lung Disease** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Heart Disease** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____**COPD** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Diabetes** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Kidney Problems** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Stroke** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Cancer** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **High cholesterol** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Thyroid** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____**Glaucoma** **(Relative-Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Child)**

____ **Other:**_____

Medications/Vitamins or herbal supplements

Name of medication	Strength	Frequency

Allergies **Reaction**
