LeBlanc PEDIATRICS
1305 West Causeway Approach
Mandeville, LA 70471
(985) 674-2227

Pediatric Health History Form

NAME: _____

DATE OF BIRTH: _____

AGE: _____

Your relationship to patient: _____

Patient's previous doctor/primary care provider:

_____

Referred by: _____

PREGNANCY & BIRTH

Where was the patient born? _____

Is the patient yours by: ☐ Birth ☐ Adoption
☐ Stepchild ☐ Other: ____

Any medical problems during pregnancy:

☐ No ☐ Yes, specify: _____

Delivery by: ☐ Vaginal birth ☐ Caesarean section

If Caesarean, why? _____

Birth weight: _____ Birth length: _____

Gestational age: _____

Group B Strep: ☐ positive ☐ negative

Newborn hearing screen: ☐ pass ☐ fail

Any medical problems during the newborn period:

☐ No ☐ Yes, specify: _____

PAST MEDICAL HISTORY (*Please include dates)

Please describe any major medical problems? _____

_____

_____

Hospitalizations: _____

Surgeries: _____

Broken bones or severe sprains: _____

Medications/vitamins: _____

_____

Herbs/home remedies: _____

_____

Allergies/reactions to medications or vaccinations:

_____

FAMILY HISTORY

Please list any deaths of immediate family members:

_____

Please list family members with any of the following conditions: (grandparents, parents, aunts/uncles, siblings)

Heart disease _____

High blood pressure _____

High cholesterol _____

Stroke _____

Bleeding or clotting disorder _____

Asthma/COPD _____

Diabetes _____

Alcoholism _____

Depression/suicide _____

Cancer, specify type _____

Genetic disorders _____

Thyroid disorders _____

ADHD _____

Other _____

NUTRITION & FEEDING

Was the patient breastfed? ☐ No ☐ Yes

If yes, how long? _____

Has the patient had any unusual feeding/dietary problems? ☐ No ☐ Yes, specify: _____

Type of Milk/Formula:

☐ Soy milk ☐ Rice milk ☐ Goat's milk

☐ Cow's milk: ☐ Nonfat ☐ 1%fat
☐ 2%fat ☐Whole

Average ounces per day: (Note: 8 ounces = 1 cup) _____

☐ Formula: _____

How much? _____ How often? _____

DENTAL HISTORY

Has the patient been seen by a dentist?

☐ No ☐ Yes, how often? _____

Any dental disease? ☐ Yes ☐ No

Date of last visit: _____

Name of your child's dentist: _____

ACTIVITY/HABITS

Sports/exercise: Type _____

How often? _____ How long (minutes)? _____

TV: hours per day? _____

Computers: hours per day? _____

Video games: hours per day? _____

Do you monitor your child's phone? ☐ Yes ☐ No

SLEEP

Hours per night: _____

Naps: How many per day? _____ How long? ____

Any sleeping problems? _____

DEVELOPMENT

At what age did the patient:

Sit alone: _____ Walk alone: _____

Say words: _____ Toilet train (daytime): _____

Girls only: Age at first menstrual period: _____

SCHOOL HISTORY

Did/does the patient attend school or preschool?

☐ No ☐ Yes

Current grade: _____

Name of school: _____

Any concerns about school performance?

☐ No ☐ Yes, specify: _____

Any concerns about depression? ☐ No ☐Yes

Any concerns about relationships with:

Teachers? ☐ No ☐ Yes, specify: _____

Peers? ☐ No ☐ Yes, specify: _____

IMMUNIZATIONS/INFECTIOUS DISEASES

*Please bring patient's immunization record to appointment

Has the patient had any of the following diseases:

☐ Chickenpox ☐ Measles ☐ Mumps

☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

EXPOSURE

Are there any concerns about lead exposure?

(i.e. old home/plumbing/peeling paint) ☐ No ☐ Yes

Do any household members smoke? ☐ No ☐ Yes

If so, do they smoke inside the home? ☐ No ☐ Yes

Are there any pets in the home?

☐ No ☐ Yes, specify: _____

SOCIAL HISTORY

Who lives at home?

Name	Relationship	Age	Highest Education Level

Are the patient's parents:

☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

If divorced or separated, when? _____

Mother's Occupation _____

Mother's Employer _____

Father's Occupation _____

Father's Employer _____

Child care: ☐ Parents

☐ Other: _____ How often? _____

Any concerns about: ☐ Alcohol use ☐ Tobacco

☐ Sexual activity ☐ Aggressive behavior

Is violence at home a concern? ☐ No ☐ Yes

Are there guns in the home? ☐ No ☐ Yes

If yes, are they secured? ☐ No ☐ Yes