Jonna L. Schmidt, M.D., P.C.
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Pediatric Health History Form

PATIENT LABEL

NAME: _____

DATE OF BIRTH: _____

AGE: _____

Your relationship to child: _____

Child's previous doctor/primary care provider: _____

Present health concerns:

Medicines/Vitamins:

Herbs/Home Remedies:

Allergies/Reactions to medicines or vaccinations:

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: ❑ Birth ❑ Adoption ❑ Stepchild ❑ Other:

Please indicate any medical problems during pregnancy

❑ None ❑ Specify: _____

Delivery by ❑ Vaginal birth ❑ Caesarean

If Caesarean, why? _____

Birth weight: _____ Birth length: _____

APGAR score 1 min. _____ 5 min. _____

Please indicate any medical problems during the baby's newborn period ❑ None (If premature, how early?)

_____

Other problems: _____

NUTRITION & FEEDING

Was your child breastfed? ❑ No ❑ Yes

If so, how long?

Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify:

_____

Milk intake now: Type ❑ Cow's milk (❑ Nonfat ❑ 1% fat ❑ 2% fat ❑ Whole) ❑ Soy milk ❑ Rice milk

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

_____

SLEEP

Hours per night _____

Naps (number & length) _____

Any sleep problems? _____

DEVELOPMENT

At what age did your child: Sit alone _____

Walk alone _____ Say words _____

Toilet train (daytime) _____

Girls only: Age at first menstrual period _____

DENTAL HISTORY

Has child been seen by a dentist? ❑ No ❑ Yes

If so, how often? _____

Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had any of the following diseases:

❑ Chickenpox ❑ Measles ❑ Mumps

❑ Rubella ❑ Meningitis ❑ Tuberculosis (TB)

EXPOSURE/HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint) ❑ No ❑ Yes

Do any household members smoke? ❑ No ❑ Yes

TV – hours per day _____

Computers – hours per day _____

Video games – hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

_____

_____

_____

Hospitalization/operations (with dates):

Broken bones or severe sprains:

FAMILY HISTORY

Please indicate any deaths of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____

High cholesterol _____

Cancer, specify type _____

High blood pressure _____

Heart disease _____

Stroke _____

Depression/suicide _____

Bleeding or clotting disorder _____

Genetic disorders _____

Asthma/COPD _____

Diabetes _____

Other: _____

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child'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 situation ❑ Parents ❑ Others (specify who and how often) _____

Concerns about your child: ❑ Alcohol use ❑ Tobacco

❑ Sexual activity ❑ Aggressive behavior

Does your child regularly use sunscreen? ❑ No ❑ Yes

Does your child use a bike helmet? ❑ No ❑ Yes

Does your child use a car seat/seatbelt consistently? ❑ No ❑ Yes

Does your home have a working smoke detector? ❑ No ❑ Yes

Are there guns in your home? ❑ No ❑ Yes

Is violence at home a concern? ❑ No ❑ Yes

SCHOOL HISTORY

Did/does your child attend school or preschool?

❑ No ❑ Yes

Current grade _____

Name of school _____

Any concerns about school performance?

_____

Any concerns about relationship with:

Teachers ❑ No ❑ Yes

Peers ❑ No ❑ Yes

If more than 4 years old: does your child have a best friend? ❑ No ❑ Yes

Sports/exercise: Type _____

How often? _____

How long (minutes)? _____

REVIEW OF SYMPTOMS: Please check any current problems your child has on the list below:

General
- ____ Fevers/chills/excessive sweating
- ____ Unexplained weight loss/gain

Eyes
- ____ Squinting/"crossed" eyes/ asymmetric gaze

Ears/Nose/Throat
- ____ Unusually loud voice/hard of hearing
- ____ Mouth breathing/snoring
- ____ Bad breath
- ____ Frequent runny nose
- ____ Problems with teeth/gums

Cardiovascular
- ____ Tires easily with exertion
- ____ Shortness of breath
- ____ Fainting

Respiratory
- ____ Cough/wheeze
- ____ Chest pain

Gastrointestinal
- ____ Nausea/vomiting/diarrhea
- ____ Constipation
- ____ Blood in bowel movement

Genitourinary
- ____ Bedwetting
- ____ Pain with urination
- ____ Discharge: penis or vagina

Musculoskeletal
- ____ Muscle/joint pain

Skin
- ____ Rashes
- ____ Unusual moles

Allergy
- ____ Hay fever/itchy eyes

Neurological
- ____ Headaches
- ____ Weakness
- ____ Clumsiness

Psychiatric/Emotional
- ____ Speech problems
- ____ Anxiety/stress
- ____ Sleep issues
- ____ Depression
- ____ Nail biting/thumb sucking
- ____ Bad temper/breath holding/ jealousy

Blood/Lymph
- ____ Unexplained lumps
- ____ Easy bruising/bleeding

Patient Name: _____

Date Completed: _____

CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE FORM

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For families who are ongoing patients of Jonna L. Schmidt, M.D., P.C.

I (we) appoint _____, who is my (our) child's
(print name of person bringing child)
_____ as my (our) proxy decision maker for consenting to non-
(specify nature of proxy's relationship to child)

urgent medical care for my (our) child listed below. I (we) have the legal right to delegate such consent to the proxy decision maker, who is an adult* and legally and medically competent to exercise the authority so delegated. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making. *(If you are designating your older, under 18 year old child to be their own proxy, they must be at least 15 years old)

Child's Name: _____ DOB: _____

LIMITATIONS
Specify any limitations on the kinds of medical services for which this authorization is given. If none, state "none".

_____

_____

Specify the time frame for which this authorization is given. (Time frame not to exceed one year)

_____

CONTACT INFORMATION
If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) child at the following telephone number(s).

Parent's Name: _____ Parent's Name: _____
Daytime Phone: _____ Daytime Phone: _____
Evening Phone: _____ Evening Phone: _____
Cell Phone: _____ Cell Phone: _____

_____ _____
Proxy Decision Maker Signature Date Signed by Proxy Decision Maker

_____ _____
Parent or Legal Guardian Name (print) Parent or Legal Guardian Name (Print)

_____ _____
Parent or Legal Guardian Signature Parent or Legal Guardian Signature

_____ _____
Date Signed By Parent Date Signed By Parent