OPTUM®

Department of Pediatrics
Colorado Springs, CO

New pediatric patient health history form

Patient's name: _____ **DOB:** _____ **Today's date:** _____

History of mother's pregnancy:

Did you start prenatal care after the 7th month?	☐ Yes	☐ No
Lose weight in pregnancy?	☐ Yes	☐ No
Have high blood pressure?	☐ Yes	☐ No
Have excessive bleeding?	☐ Yes	☐ No
Have pre-term labor?	☐ Yes	☐ No
Take medication other than prenatal vitamins?	☐ Yes	☐ No
Drink alcoholic beverages?	☐ Yes	☐ No
Consult your provider for any illness?	☐ Yes	☐ No
Smoke?	☐ Yes	☐ No
Have any major injuries?	☐ Yes	☐ No
Have X-rays?	☐ Yes	☐ No

How much weight did you gain?_____

Birth history:

Was the baby full term?	☐ Yes	☐ No
Was the baby a vaginal delivery?	☐ Yes	☐ No
Was the baby perfectly healthy?	☐ Yes	☐ No
Did the baby go home with mom?	☐ Yes	☐ No

Birth weight:_____

Infant history:

Was the baby irritable or colicky?	☐ Yes	☐ No
Any feeding problems?	☐ Yes	☐ No
Was the baby exceptionally active?	☐ Yes	☐ No

Milestones: Has he/she:

Walked before 15 months?	☐ Yes	☐ No
Sat alone before 8 months?	☐ Yes	☐ No
Said first word (other than mama/dada) by age _____	☐ Yes	☐ No

Miscellaneous: Has he/she:

Ever been hospitalized?	☐ Yes	☐ No
Had any broken bones?	☐ Yes	☐ No
Had a head injury with loss of consciousness?	☐ Yes	☐ No
Had a lot of ear infections?	☐ Yes	☐ No
Ever had a seizure/convulsion?	☐ Yes	☐ No
Had difficulty with vision/hearing?	☐ Yes	☐ No

Had sleep problems such as:

Taking longer than 30 minutes to fall asleep	☐ Yes	☐ No
Excessive number of nightmares	☐ Yes	☐ No
Frequent sleep walking/talking	☐ Yes	☐ No
Bed wetting	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No

Patient's name: _____ **Date:** _____

Is he/she currently:

In daycare	☐ Yes	☐ No
In school	☐ Yes	☐ No

Has he/she ever had:

MRI/CT?	☐ Yes	☐ No
EEG?	☐ Yes	☐ No
Physical/occupational speech therapy?	☐ Yes	☐ No

Have you ever considered he/she to be:

Too active?	☐ Yes	☐ No
Withdrawn?	☐ Yes	☐ No
Unhappy?	☐ Yes	☐ No

Please list CURRENT medications including dose and time of day taken:

Medication:	**Dose:**	**How taken:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family history:

Has any blood relative ever had:

Learning or reading problem?	☐ Yes	☐ No
History of severe depression?	☐ Yes	☐ No
Mental retardation?	☐ Yes	☐ No
Drug or alcohol addiction?	☐ Yes	☐ No
Tics/Tourettes syndrome?	☐ Yes	☐ No
Birth defects?	☐ Yes	☐ No
Trouble with law enforcement?	☐ Yes	☐ No
Any diseases that commonly run in the family?	☐ Yes	☐ No

Please list:

_____	_____
_____	_____
_____	_____
_____	_____

Questions were answered by:

Parent:_____ Other:_____

Do you have any specific questions?

_____

_____

Patient/Guardian signature: _____ Date: _____