MOUNTAINSTAR
South Jordan
Family Medicine
affiliated with St. Mark's Hospital

Pediatric Health History Form

Child's Name: ______________________________________ Date Of Birth: ______________________
Child's Previous Doctor: ________________________________
Allergies/ Reactions to Medications or Vaccines: ____
Current Medications/ Vitamins: ____
Current Problems/ Concerns: ____

Past Medical History: (*Please Check All That Apply*)

☐ Asthma/Hay Fever/Eczema ☐ Chicken Pox ☐ RSV
☐ Broken Bones ☐ Croup ☐ Attention Problems
☐ Frequent Ear Infections ☐ Pneumonia ☐ Other___________________________________

(Please explain any "Yes" answers)____
☐ Hospitalizations/Surgeries (with dates): ____

Immunizations/Exposures/Habits: (Please bring a copy of your child's immunization record to all well child appointments)

Are your child's immunizations up to date? ☐Yes ☐No
Do any household members smoke? ☐Yes ☐No
Any concerns about lead exposure (old home/ plumbing/ peeling paint)? ☐No ☐Yes
TV, computers, video games: Hours per day __________
Physical activity: Hours per day __________

Pregnancy & Birth:

Any problems with the pregnancy? ☐No ☐Yes (Please explain) ____________________________________
Delivered by: ☐Vaginal Birth ☐Cesarean Birth

Family History: 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 ______________________ Kidney disease ______________________
Depression/anxiety ______________________ Bleeding/clotting disorder ______________________
Genetic Disorders ______________________ Asthma/COPD ______________________
Diabetes ______________________ Other ______________________

Social History:

Who does child live with?
☐Mom ☐Dad ☐Siblings (how many) _______ ☐Grandma ☐Grandpa ☐Other ____________________
The Child's parents are: ☐Married ☐Unmarried, but living together ☐Separated ☐Divorced
Does your Child attend preschool/ school? ☐No ☐Yes Any concerns at school? ☐No ☐Yes, explain______________

Review of Systems: *(Please check any current problems your child is experiencing)*

Allergy
☐ Hay fever/itchy eyes
☐ Unexplained weight loss/gain

General
☐ Fevers/chills/excessive sweating
☐ Unexplained weight loss/gain

Eyes
☐ Squinting
☐ Crossed eyes

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

Respiratory
☐ Coughing/wheezing
☐ Chest pain

Cardiovascular
☐ Tires easily with exertion
☐ Shortness of breath
☐ Fainting

Gastrointestinal
☐ Nausea
☐ Constipation
☐ Blood in bowel movement

Genitourinary
☐ Bedwetting
☐ Pain with urination
☐ Discharge: penis/vagina

Neurological
☐ Headaches
☐ Weakness

Musculoskeletal
☐ Muscle/joint pain

Blood/Lymph
☐ Unexplained lumps
☐ Easy bruising/bleeding

Psychiatric
☐ Speech problems
☐ Depression
☐ Sleep issues

Skin
☐ Rashes
☐ Unusual moles