GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

Pediatric Health History
Ages 0-5 years

Patient Name:_____ **DOB:**_____ **Today's Date:**_____

Preferred Pharmacy: **City Market** **Clark's Pharmacy** **Walmart**

Past Medical History

Please list any past medical history below: (examples include asthma, diabetes, ADHD, etc.)

Diagnosis or condition	Date of diagnosis or onset
1.	
2.	

Surgical History / Hospitalizations:

Surgery / Hospitalization	Date	Reason
1.		
2.		

Medication History (include over-the-counter, herbal supplements, and vitamins):

☐ No medications at all ☐ See attached medications list

Medication name	Dose	How often
1.		
2.		

Allergies: ☐ No allergies at all ☐ No known drug allergies

☐ Drug/medication allergies ☐ Food allergies ☐ Environmental allergies

Allergen	Reaction
1.	
2.	

Family History *(does child have any blood relatives with these problems—Mother/Father/Siblings?)*

Heart attack (who and what age):_____

Cancer (who and what age):_____

Other pertinent conditions (who and what age, list condition):_____

How many siblings does the child have:_____

Social History

Parents Marital Status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed

Childcare away from parents: ☐ None ☐ Relative ☐ Nanny ☐ Private sitter ☐ Daycare

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Child's diet is: ☐ Breastfed ☐ Formula ☐ Solids ☐ Special diet (diabetic, gluten-free)

Playtime / Exercise: ☐ None ☐ Occasional ☐ Moderate

Sex: ☐ Female ☐ Male Potty training: ☐ Yes ☐ No

Pets in the home: ☐ Yes ☐ No *If yes,* what types_____

Smoke exposure in the home: ☐ Yes ☐ No CO detectors in the home: ☐ Yes ☐ No

Guns in the home: ☐ Yes ☐ No Where stored: ☐ Inside ☐ Outside Locked: ☐ Yes ☐ No

Bike helmet use: ☐ Always ☐ Only w/strider or motorized ☐ No, use in bike trailer ☐ Never

Car seat used: ☐ Yes ☐ No

Health Maintenance / Immunizations

Is child up to date with childhood immunizations? ☐ Yes ☐ No ☐ Unknown

If no / unknown, would you like to discuss vaccines that are due today? ☐ Yes ☐ No

Physical limitations

Please list any physical limitations your child has:_____

Other providers involved in child's care: (include dentist, therapists, specialists, etc.)

Name	Specialty	Reason / Last visit
1.		
2.		

Are there any other important things we should know about your child?

_____

_____