Pediatric Health History

Urbana Student Health Center

Name: ________________________________ DOB: _______________

Parent/Guardian: ____________________________ Relationship to Child: ________________

1. What other doctors has your child seen in the last year?
   Please list: ____

2. Is your child allergic to any medicines? □ Yes □No
   If yes, please list: ______________________________

3. Does your child take any medicines (including vitamins and over-the-counter medicines)? □ Yes □ No
   If yes, please list below:

Name of medicine	Prescribed by	Reason taken	How long taken
____________________	______________	______________	_____________
____________________	______________	______________	_____________

4. Has your child ever been hospitalized overnight or had any type of surgery? □ Yes □ No
   If yes, what age and please describe:

Age	Problem/Type of Surgery
______________	____
______________	____

5. Has your child ever had any serious injuries, including sports related injuries? □ Yes □ No
   If yes, please explain: ____

6. Please check if your child has ever had any of these health problems:

□ ADHD/learning disability
□ Allergies/ hay fever/ foods/ stinging insects
□ Asthma/ wheezing with exercise
□ Bladder or kidney infection
□ Cancer (type: _______________)
□ Chicken Pox
□ Depression/ emotional disorder
□Vision or hearing problems
□ Skin Problems (please circle)
Eczema Rash Blisters Itch Severe acne
Infection: Staph Warts Fungal Scabies Molluscum

□ Heart disease or problems
□ Heat illness (heat stroke/fainting)
□ Hepatitis (liver disease)
□ Hernia
□ Anemia
□ Mononucleosis (Mono)
□ Scoliosis (curved spine)
□ Sickle Cell Anemia or trait/blood disorder
□ Other: ________________________

□ Eating Disorder
□ Headaches/Migraines
□ Head injury/ concussion
□ Seizures/Epilepsy
□ Diabetes
□ Tuberculosis
□ Pneumonia

7. Family History: Has any of the child's blood relatives, living or deceased, had any of these problems? If yes, please state age it started and the relationship to the child.

	Age	Relationship		Age	Relationship
□ Allergies/asthma	_____	_______________	□ High Cholesterol	_____	_______________
□ Alcohol use	_____	_______________	□ Mental Illness	_____	_______________
□ Depression	_____	_______________	□ Migraine headaches	_____	_______________
□ Diabetes	_____	_______________	□ Obesity	_____	_______________
□ Drinking Problem/alcoholism	_____	_______________	□ Seizures/epilepsy	_____	_______________
□ Drug addiction	_____	_______________	□ Smoking	_____	_______________
□ Heart attack or stroke			□ Thyroid Disease	_____	_______________
Before age 50	_____	_______________	□ Tuberculosis/ lung disease	_____	_______________
After age 50	_____	_______________	□ High blood pressure	_____	_______________
□ Cancer (Type: ____________)	_____	_______________			

Signature of parent/guardian: ________________________________ Date: _______________

Name: ____ DOB: _______________

Has there been any change to your child's medical information since the form was completed?

This may include taking new medicines, new health problems or serious injuries, surgeries or being in the hospital overnight.

Date	Changes	Signature