UW Medicine
NORTHWEST PRIMARY CARE

Patient Label

Pediatric Health History
New Patient Form

DATE: _____

NAME: Last _____ **First** _____ **MI**_____**Gender:** _____ **Birthdate:** _____

REASON FOR VISIT: _____

Allergies: **Medication or Substance** **Reaction**

☐ No Allergies _____ _____

_____ _____

_____ _____

Current Medications: **Label – Name** **Dose** **Frequency**

OR _____ _____ _____

☐ See Attached List _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History

Relationship	First Name	Status (circle)	No Known Problems	Arthritis	Asthma	Birth Defects	Cancer	Clotting Disorder	Depression	Diabetes	Early Sudden Death	Hearing Loss	Heart Disease	Hypertension	Kidney Problems	Mental Illness	Stroke	Substance /Drug Abuse	Vision Loss	Other:
Mother		alive deceased																		
Father		alive deceased																		
Maternal Grandmother		alive deceased																		
Maternal Grandfather		alive deceased																		
Paternal Grandmother		alive deceased																		
Paternal Grandfather		alive deceased																		
Brother		alive deceased																		
Sister		alive deceased																		
Maternal Aunt		alive deceased																		
Maternal Uncle		alive deceased																		
Paternal Aunt		alive deceased																		
Paternal Uncle		alive deceased																		
Other:		alive deceased																		

Are there any major illnesses in the family that we are not already aware of? _____
_____

Are there any major stressors in the family (illness, moves, death, separation)? _____
_____

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Health Maintenance

	Yes	No		
Eye exam	☐	☐	When _____	Where _____
Dental exam twice a year	☐	☐	When _____	Where _____
Dos your child brush their teeth daily?	☐	☐		
Does your child have a regular sleep routine?	☐	☐		
Are satisfied with your child's weight	☐	☐		
Is your child getting daily exercise?	☐	☐	How many hours of active play per day? _____	
Is there TV or Internet in the child's room?	☐	☐	How many hours of screen time? _____	

(Female only)
Has your daughter begun to have periods? ☐ ☐ If yes, are they regular and minimally uncomfortable? _____

(13 years and older only)

Does your child use tobacco?	☐	☐	If yes, how often and what type? _____
Does your child use recreational drugs?	☐	☐	If yes, how often and what type? _____
Does your child use alcohol?	☐	☐	If yes, how often? _____
Is your child sexually active?	☐	☐	If yes, how often? _____
			Partners: ☐ Male ☐ Female ☐ Both Birth Control: _____

Immunizations

	Yes	No		
Tetanus or TDAP	☐	☐	When _____	Where _____
Hep B	☐	☐	When _____	Where _____
Hep A	☐	☐	When _____	Where _____
Flu	☐	☐	When _____	Where _____
Varicella	☐	☐	When _____	Where _____
MMR	☐	☐	When _____	Where _____
PCV	☐	☐	When _____	Where _____

Behavioral and Mental Health

Do you have any concerns about how your child is learning, developing and behaving? _____
_____
_____

Preventative Health/ Risk Factors

Does your child always ride in a car seat, and in the back seat?	☐ Yes	☐ No	☐ N/A
Does your child always wear a seatbelt?	☐ Yes	☐ No	☐ N/A
Does your child have or wear a helmet while riding a bicycle, tricycle, skateboarding, ect?	☐ Yes	☐ No	☐ N/A
Is your child exposed to anyone who smokes?	☐ Yes	☐ No	☐ N/A
Are there any guns in the home?	☐ Yes	☐ No	☐ N/A
If yes, are they always empty and locked?	☐ Yes	☐ No	☐ N/A
Do you have smoke detectors and fire extinguisher in the home and are they checked yearly?	☐ Yes	☐ No	☐ N/A
Has your child had close contact with anyone who has tuberculosis (TB) or is at risk for TB (visited Africa, Latin America, Caribbean country, been homeless or jailed, IV drug user, HIV positive)?	☐ Yes	☐ No	☐ N/A

Nutrition

(For children up to 24 months)
Is your child feeding well? ☐ Yes ☐ No ☐ N/A
Is your child breast fed? ☐ Yes ☐ No ☐ N/A If yes, how often? _____
Is your child formula fed? ☐ Yes ☐ No ☐ N/A If yes, how often and what formula? _____

Does your child eat fast food? ☐ Yes ☐ No ☐ N/A If yes, how many times per week? _____

Are satisfied with your child's weight?	☐ Yes	☐ No
Does your child eat a variety of fruits, vegetables, dairy and meat daily?	☐ Yes	☐ No
Is your child drinking low – fat milk, limited to no more than 2-3 cups per day?	☐ Yes	☐ No
Are juice and sugary drinks limited to 0-1 serving per day?	☐ Yes	☐ No
Is your child taking vitamin supplements?	☐ Yes	☐ No