MIT Health
Pediatric Primary Care

MIT Health
Massachusetts Institute of Technology
77 Massachusetts Ave, Building E23
Cambridge, MA 02139

Pediatrics History Form

Dear Parent:
This is a health questionnaire on your child. Please complete this form. Bring it with you at the time of an appointment.
Date completed:

Child's Name _____ Date of Birth _____

Contact Information for Parent 1

Name _____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Contact Information for Parent 2

Name _____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

This child lives with

☐ Mother ☐ Father ☐ Mother/Father ☐ Mother/Partner ☐ Father/Patner ☐ Grandparent/Other

MIT Affilition

Person _____ Position _____ Department _____

Family History

1. Parent 1 Age _____ Current Health _____

Past Health Problems _____

Ethnicity _____ Education/Training _____

2. Parent 2 Age _____ Current Health _____

Past Health Problems _____

Ethnicity _____ Education/Training _____

3. Marital Status of Parents _____

4. Other Children in Family:

Date of Birth	Gender	Name	Healthy or Medical Issues?

5. Are there cultural or religious practices that might affect your child's medical care? ☐ no ☐ yes

If yes, please explain (e.g. blood transfusion, dietary rules, etc.): _____

6. Is there tobacco use in/around your household? ☐ no ☐ yes

7. Is there a history in the family/a blood relative of:

			If yes, state relationship to child
a. Allergies	☐ no	☐ yes	
b. Anxiety	☐ no	☐ yes	
c. Asthma	☐ no	☐ yes	
d. Birth Defects/Genetic Problems	☐ no	☐ yes	
e. Cancer	☐ no	☐ yes	
i. Brain	☐ no	☐ yes	
ii. Breast	☐ no	☐ yes	
iii. Colon	☐ no	☐ yes	
iv. Ovarian	☐ no	☐ yes	
v. Skin	☐ no	☐ yes	
vi. Thyroid	☐ no	☐ yes	
vii. vii. Other (describe and state relationship to child):			
f. Depression	☐ no	☐ yes	
g. Diabetes	☐ no	☐ yes	
h. Hearing Loss	☐ no	☐ yes	
i. Heart Attack	☐ no	☐ yes	
j. Heart Disease	☐ no	☐ yes	
k. Hepatitis	☐ no	☐ yes	
l. High Blood Pressure	☐ no	☐ yes	
m. High Cholesterol	☐ no	☐ yes	
n. Learning Disability	☐ no	☐ yes	
o. Mental Illness	☐ no	☐ yes	
p. Seizures	☐ no	☐ yes	
q. Thyroid Problems	☐ no	☐ yes	
r. Tuberculosis	☐ no	☐ yes	

Prenatal History

8. While pregnant, did mother have:	☐ no	☐ yes
a. Bleeding or spotting	☐ no	☐ yes
b. German measles (Rubella)	☐ no	☐ yes
c. Gestational diabetes	☐ no	☐ yes
d. High blood pressure	☐ no	☐ yes
e. Illness other than cold/flu	☐ no	☐ yes
f. Kidney disease	☐ no	☐ yes
g. Premature labor	☐ no	☐ yes
h. Threatened miscarriage	☐ no	☐ yes
i. Toxemia	☐ no	☐ yes
9. Were medications or herbs taken during pregnancy?:	☐ no	☐ yes

If yes, what kind _____

10. Was a fertility treatment used for this pregnancy? ☐ no ☐ yes

If yes, what kind _____

Birth History

11. Where was child born: ☐ no ☐ yes

12. Was labor induced? ☐ no ☐ yes

13. Was labor helped by medication? ☐ no ☐ yes

14. Duration of labor: ☐ no ☐ yes

15. Was child born early (less than 38 weeks)? ☐ no ☐ yes

16. Was child born late (after 42 weeks)? ☐ no ☐ yes

17. What was the method of delivery: ☐ no ☐ yes

☐ Breech

☐ Caesarean (Please state reason) _____

☐ Forceps

☐ Spontaneous vaginal

18. Child's birth weight: _____

19. Apgar Score (if known): _____

20. During the hospital stay, did child have any of the following:

a. Antibiotic treatment ☐ no ☐ yes

b. Blue spells ☐ no ☐ yes

c. Convulsions ☐ no ☐ yes

d. Jaundice ☐ no ☐ yes

e. Skin rash ☐ no ☐ yes

f. Did child remain in hospital longer than mother? ☐ no ☐ yes

21. How was/is baby fed?

☐ Bottle

☐ Breast

Developmental History

22. At what age did child: Age

a. Hold up head _____

b. Roll over _____

c. Sit unsupported _____

d. Stand alone _____

e. Walk _____

f. Talk _____

g. Toilet train _____

h. Feed him/herself _____

i. Dress him/herself _____

Immunizations

PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES And TB (Tuberculosis) Testing or BCG Vaccination

Past Medical History

23. Has the child had

- **a.** Blood: anemia (iron deficiency, Sickle Cell, Thalessemia) ☐ no ☐ yes
- **b.** Blood transfusions ☐ no ☐ yes
- **c.** Chicken pox (Varicella) ☐ no ☐ yes
- **d.** Contusions ☐ no ☐ yes
- **e.** Convulsions ☐ no ☐ yes
- **f.** Fractures ☐ no ☐ yes
- **g.** German Measles (Rubella) ☐ no ☐ yes
- **h.** Hospitalizations ☐ no ☐ yes
- **i.** Measles (Rubeola) ☐ no ☐ yes
- **j.** Meningitis ☐ no ☐ yes
- **k.** Mumps ☐ no ☐ yes
- **l.** Operations ☐ no ☐ yes

If yes, what kind _____

- **m.** Poison ingestion ☐ no ☐ yes
- **n.** Other serious medical illnesses ☐ no ☐ yes

If yes, what kind _____

- **o.** Is your child currently taking any medications, vitamins or herbs? ☐ no ☐ yes

Medication	Strength/Dose	How Often

- **p.** Reaction to medication or food (allergy) ☐ no ☐ yes

If yes, please explain _____

- **q.** Any chronic or recurring pain? ☐ no ☐ yes

If yes, please explain _____

24. Eyes

- **a.** Any visual problems? ☐ no ☐ yes
- **b.** Do eyes look crossed? ☐ no ☐ yes
- **c.** Does the child wear eyeglasses? ☐ no ☐ yes

25. Ears

- **a.** Any hearing problems? ☐ no ☐ yes
- **b.** Three or more ear infections? ☐ no ☐ yes

26. Nose

- **a.** Does the child have frequent attacks of sneezing or rubbing his/her nose? ☐ no ☐ yes
- **b.** Has the child had frequent nose bleeds? ☐ no ☐ yes

27. Throat :

- **a.** Does your child have three or more strep throat infections per year? ☐ no ☐ yes

28. Heart

Have you ever been told your child has

- **a.** A heart murmur? ☐ no ☐ yes
- **b.** Heart defect? ☐ no ☐ yes
- **c.** High blood pressure? ☐ no ☐ yes

29. Lungs

Has your child ever had

- **a.** Asthma/wheezing? ☐ no ☐ yes
- **b.** Bronchitis or pneumonia? ☐ no ☐ yes
- **c.** Chronic cough? ☐ no ☐ yes

30. Does your child tire easily?

31. Abdomen

Has your child ever had

- **a.** Blood in bowel movement? ☐ no ☐ yes
- **b.** Difficulty with appetite or eating? ☐ no ☐ yes
- **c.** Frequent abdominal pain? ☐ no ☐ yes
- **d.** Frequent vomiting or diarrhea? ☐ no ☐ yes
- **e.** Jaundice? ☐ no ☐ yes
- **f.** Marked weight loss? ☐ no ☐ yes

If yes, please explain _____

32. Kidney

- **a.** Does your child ever complain of burning or frequency of urination? ☐ no ☐ yes
- **b.** Does your child wet the bed? ☐ no ☐ yes
- **c.** Has there ever been blood in the urine? ☐ no ☐ yes
- **d.** Has your child ever had a urinary tract infection? ☐ no ☐ yes

33. Skin

- **a.** Acne? ☐ no ☐ yes
- **b.** Any sensitivity or allergy? ☐ no ☐ yes
- **c.** Eczema or atopic dermatitis? ☐ no ☐ yes

34. Extremities

Has your child

- **a.** Had weakness or paralysis of arms or legs? ☐ no ☐ yes
- **b.** A persistent limp? ☐ no ☐ yes
- **c.** Every worn corrective shoes or braces? ☐ no ☐ yes

35. Neurological

Has your child ever had

- **a.** Breath holding? ☐ no ☐ yes
- **b.** Convulsions or seizures? ☐ no ☐ yes
- **c.** Dizziness? ☐ no ☐ yes
- **d.** Fainting? ☐ no ☐ yes
- **e.** Frequent headaches? ☐ no ☐ yes
- **f.** Temper tantrums? ☐ no ☐ yes

36. Is your child

- **a.** Impulsive? ☐ no ☐ yes
- **b.** Lacking in self-control? ☐ no ☐ yes
- **c.** Overactive? ☐ no ☐ yes
- **d.** Does your child have problems with:
  - **i.** Attending school? ☐ no ☐ yes
  - **ii.** Attention span? ☐ no ☐ yes
  - **iii.** Learning? ☐ no ☐ yes
  - **iv.** Mood? ☐ no ☐ yes
  - **v.** Parents? ☐ no ☐ yes
  - **vi.** Peers? ☐ no ☐ yes
  - **vii.** Siblings? ☐ no ☐ yes
  - **viii.** Sleep? ☐ no ☐ yes
  - **ix.** Are there concerns about physical, sexual, or emotional abuse? ☐ no ☐ yes

    (You may call Mental Health Services to set up an evaluation at 617.253.2916 for any of the above.)

37. Has your child begun puberty? ☐ no ☐ yes

38. Any other concerns you would like to discuss? _____

_____

Patient or Guardian Signature _____ Date _____

Provider Name _____ Date Reviewed _____