Pediatric Health Assessment

University Health Services
University of Massachusetts
Amherst, MA 01003–9288
413–577–5000

L A B E L	
	IDX MRN #____
	Last ____ First ____ M____
	DOB____ Sex ____ Time ____
	DOS____ Clinic ____
	Visit #____ Provider ____

Name: ____ Date of Birth: ____
Address: ____ Phone #: ____
____

Name of:	DOB:	Occupation:	Healthy?
Parent: ____	____	____	____
Parent: ____	____	____	____
Brothers/Sisters:			
____	____	____	____
____	____	____	____
____	____	____	____
____	____	____	____

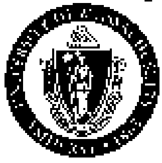
Are parents living together? ❍ Yes ❍ No Care outside of home? ❍ Yes ❍ No
Is child biological or adopted? ____ Siblings biological or adopted? ____
Others living in the household: ____

Please check Yes or No or fill in the blanks:

1. Were there any problems, infections or abnormal tests during pregnancy? ❍ Yes ❍ No
2. Was any treatment or medication required during pregnancy ❍ Yes ❍ No
3. Mother's age when child born: ____
4. Was delivery vaginal or cesarean? ____
5. Any difficulties during labor or delivery? ❍ Yes ❍ No
6. Any problems at birth such as breathing difficulty, infection, jaundice? ❍ Yes ❍ No
7. Was the baby premature? ❍ Yes ❍ No
   If so, how many weeks early? ____
8. Weight at birth: ____ lb ____ oz / ____ kg
9. Place where born: ____
10. Any problems during the first month of life? ❍ Yes ❍ No
11. Any concerns about your child's development? ❍ Yes ❍ No
12. In school, present grade: ____
13. Has your child had to stay in the hospital? ❍ Yes ❍ No

Date	Name/Location of Hospital	Reason
____	____	____
____	____	____
____	____	____

14. Is your child allergic to any medications? ❍ Yes ❍ No
    Please list: ____
    ____
15. Is your child allergic to any foods? ❍ Yes ❍ No
    Please list: ____
    ____
16. Does your child take any medications currently? ❍ Yes ❍ No
    Please list: ____
    ____
17. Does your child take fluoride? ❍ Yes ❍ No
18. Does your child take vitamins/supplements/herbal remedies? ❍ Yes ❍ No
    Please list: ____
    ____



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Tax ID # 04–3167352

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DOB__________ Sex __________ Time __________
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Please check any of the following if your child has ever had:

- ❍ Skin conditions, eczema
- ❍ Eye problems, glasses
- ❍ Frequent ear infections
- ❍ Difficulty with speech/hearing
- ❍ Frequent nose bleeds
- ❍ Excessive bleeding/easy bruising
- ❍ Pneumonia/lung problems
- ❍ Asthma/allergies
- ❍ Heart murmur/palpitations
- ❍ Anemia
- ❍ Frequent stomach aches
- ❍ Frequent diarrhea
- ❍ Constipation/stool withholding
- ❍ Black stool/blood in stool
- ❍ Abuse (physical/mental/sexual)
- ❍ Chickenpox (date: __________)
- ❍ Kidney or bladder infections
- ❍ Blood protein in urine
- ❍ Bedwetting
- ❍ Problems with periods
- ❍ Lead poisoning
- ❍ Depression/anxiety
- ❍ Head injuries/loss of consciousness
- ❍ Dizziness/fainting
- ❍ Seizures
- ❍ Frequent headaches/migraines
- ❍ Eating Disorder (anorexia/bulimia)
- ❍ Trouble gaining/losing weight
- ❍ Developmental delay
- ❍ Broken Bones/Stitches
- ❍ Problems concentrating/learning
- ❍ Other: ____________________

What interests, hobbies or activities does your child do outside of school?____________________

How many hours a day does your child watch TV? __________

Are there any financial, personal or family problems that may be affecting your child?____________________

Are there any guns in the house? __________ What year was your home/apt built? __________

Do you have any concerns about your child's speech, hearing, or vision?____________________

Does your child have good friends? ____________________

Family History–please check any of the following conditions which relatives have had:
(parents, aunts, uncles, cousins, grandparents)

- ❍ Asthma/lung problems
- ❍ Eczema/skin problems
- ❍ Allergies (seasonal/food/meds/bees)
- ❍ Tuberculosis
- ❍ High blood pressure
- ❍ Stroke
- ❍ Heart attack under age 55
- ❍ High cholesterol
- ❍ Thyroid problem/goiter
- ❍ Deafness other than elderly
- ❍ Cataract/glaucoma
- ❍ Astigmatism/amblyopia (lazy eye)
- ❍ Seizures
- ❍ Diabetes
- ❍ Anorexia/bulimia/obesity
- ❍ Cancer
- ❍ AD(H)D/learning disabilities
- ❍ Inflammatory/ irritable bowel disease
- ❍ Headaches/migraines
- ❍ Anemia/blood or bleeding disorder
- ❍ Kidney disease/stones/ blood in urine
- ❍ Cystic fibrosis
- ❍ Mental retardation/birth defects
- ❍ Neurologic/muscle diseases
- ❍ Problem taking birth control pills
- ❍ Mental health conditions/ schizophrenia
- ❍ Depression/anxiety
- ❍ Inherited genetic diseases
- ❍ Death before age 50
- ❍ Alcoholism/drug use
- ❍ Abuse (physical, mental, sexual)
- ❍ Other: ____________________

____________________ Parent signature
__________ Date
____________________ Provider Signature