PennState Health
Milton S. Hershey Medical Center

PEDIATRIC HEALTH ASSESSMENT

Patient's Name: _____ Date of Birth: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Parents Marital Status: Married _____ Single _____ Widowed _____ Divorced _____
Living Together _____ Separated _____

Parental involvement in child care: Father Yes / No Mother Yes / No

What language do you or your child best understand _____

Who lives in the household _____

Family Physician or Pediatrician: _____

How do you or your child best learn:

a. One on One Instruction _____
b. Audio Visual Information _____
c. Written Information _____
d. Group Instruction _____
e. Demonstration/Practice _____
f. Other _____

Is your child exposed to anyone who uses tobacco? Yes / No Who? _____

Does anyone in the household consume alcohol? Yes / No

Does anyone in the household use any other substances Yes / No If yes, type_____

Is your child afraid of anyone? Yes / No

Has your child ever been physically or emotionally hurt by anyone: Yes / No

Are there pets in the household? Yes / No Type:_____

Water type? City / Well

School District _____

School Concerns: Yes / No

Does your child wear a bike helmet? Yes / No

Does your child use a car seat, booster seat, or seat belt? Yes / No

Do you or your child have any special needs we should be aware of so that we can better serve you?

_____

_____

Updated				
Reviewed By				

OVER

PEDIATRIC HEALTH ASSESSMENT

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Previous Surgery	Complications	Date

Name of Current Medications:

Does your child have allergies? Yes / No If yes, please list:

Medications: _____

Enviromental: _____

Immunizations up to date☐ Yes ☐ No

Has the patient ever had or experienced any of the following:

General			**GI**			**GU**		
Weight loss	☐ Yes	☐ No	Difficulty swallowing	☐ Yes	☐ No	Painful voiding/urinating	☐ Yes	☐ No
Weight gain	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Bed wetting	☐ Yes	☐ No
Eyes			Reflux	☐ Yes	☐ No	Urinary tract infection	☐ Yes	☐ No
Glasses/Contact	☐ Yes	☐ No	Blood in stool	☐ Yes	☐ No	Toilet trained	☐ Yes	☐ No
ENT			Constipation	☐ Yes	☐ No	**Hematologic/Lymphatic**		
Hearing problems	☐ Yes	☐ No	**Musculoskeletal**			Anemia	☐ Yes	☐ No
Cardiovascular			Scoliosis	☐ Yes	☐ No	Bleeding disorder	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	**Integumentary**			**Endocrine**		
Chest pain	☐ Yes	☐ No	Rashes	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	**Neurologic**			Thyroid disease	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Seizures	☐ Yes	☐ No	**Immunologic**		
Respiratory			Hydrocephalus	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Asthma/wheezing	☐ Yes	☐ No	Developmental Delay	☐ Yes	☐ No	Im**General**		
Bronchitis/Pneumonia	☐ Yes	☐ No	Cerebral Palsy	☐ Yes	☐ No	Weight loss	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No	Numbness arms/legs	☐ Yes	☐ No	Weight gain	☐ Yes	☐ No
Home oxygen therapy	☐ Yes	☐ No	Unsteady gait	☐ Yes	☐ No	**Eyes**		
Shortness of breath	☐ Yes	☐ No	Difficulty speaking	☐ Yes	☐ No	Glasses/Contact	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No			

Family Medical History:

Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Childhood Deaths	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Anesthesia Complications	☐ Yes	☐ No	Blood/Bleeding Disorders	☐ Yes	☐ No	Arthritis		

Name of Person Completing Form _____ Date _____ Time _____

Relationship to Patient _____

Signature of person who reviewed and discussed above with the provider. _____ Date _____ Time _____

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