Valle
Verde
Pediatrics

15525 Pomerado Road, Ste B1
Poway, CA 92064
tel: 858-487-8333 fax: 858-487-0856

Initial Pediatric Health Assessment

Full Name of Child:	Date of Birth	Social Security #:	Today's Date

Child's Sex: Male Female	Mother's full Name	Mother Soc Security #	Mother Date of Birth
Current age of child	Father's full Name	Father Soc Security #	Father Date of Birth

Birth History

Hospital, City, State		Pregnancy/Delivery Problems?
Delivery Type		Post Partum Complications?
Was baby discharged with mother? [ ] Yes [ ] No Babies Length of Stay?		Why not?
Birthweight lbs. oz.	Length	[ ] Breast [ ]Formula

Medical History

**Allergies to food, medications, or environmental antigens?	
Hospitalizations	
Surgeries	
Injuries/ Accidents	
Significant Illnesses	

Child Has Had (Indicate Date):

[ ] Chicken Pox _____
[ ] Mumps_____
[ ] Measles_____
[ ] TB_____
[ ] Hearing Problems_____
[ ] Vision Problems_____
[ ] Colic / Abdominal Pain_____
[ ] Seizures_____
[ ] Headaches_____
[ ] Pneumonia_____
[ ] Bladder Infections_____
[ ] Sickle Cell Disease / Trait_____
[ ] Heart Murmur_____
[ ] Sinus Problems_____
[ ] Ear Infections_____
[ ] Hay Fever_____
[ ] Eczema_____
[ ] Anemia_____
[ ] Any Other Problems _____

Present Medications:

Prescriptions	Over the Counter (OTC)

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Immunization History

Immuniation Record Obtained? [ ] Yes [ ] No			Immunizations Current? [ ] Yes [ ] No		
Date of last PPD:			Results		
DTP	#1	#2	#3	#4	Booster
IPV	#1	#2	#3	Booster	
HIB	#1	#2	#3	#4	
MMR	#1	#2			
Hep B	#1	#2	#3		
Varicella	#1	#2			
Pneumococcal	#1	#2	#3	#4	
Influenza	Date	Date	Date		
Hep A	#1	#2			
Meningococcal	#1	#2			
Rotavirus	#1	#2	#3		
HPV	#1	#2	#3		

Lab Tests (If Applicable)

[ ] Blood lead test date:_____
[ ] Blood hgb/hct date:_____
[ ] Cholesterol date:_____
[ ] Newborn Metabolic Screen date:_____
[ ] Urinalysis date:_____
[ ] Pap test date:_____

Family Medical History

[ ] Alcoholism
[ ] Anemia
[ ] Asthma
[ ] Birth Defects
[ ] Cancer
[ ] Deafness
[ ] Depression
[ ] Diabetes
[ ] Drug Abuse
[ ] Eczema
[ ] Hay Fever
[ ] Heart Disease
[ ] High Blood Pressure
[ ] Kidney Disease
[ ] Learning Disease
[ ] Other _____
[ ] Mental Retardation
[ ] Obesity
[ ] Seizures
[ ] Sickle Cell Disease / Trait
[ ] Stroke
[ ] Thyroid Problem
[ ] Tuberculosis

Social / Cultural History

School Name	Grade Level
Language Spoken at home	Number of Family member living in same house
Primary caretaker at home	

Family Data

Relationship	Name	Occupation	Date of Birth
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			