Date______________

Pediatric Annual Wellness History

Name____**Date of Birth**__________

Current Medications, Supplements, Vitamins

____

____

Allergies

____

____

New Conditions or Surgeries since last seen

____

____

Nutrition/Growth:

Type of milk: How many cups/day: Cow_______ Soy_______ Nut________
Type of water: How many cups/day: Bottled_____ Tap_______ Juice/Other________
Concerns about eating habits____

How many hours of sleep at night_________ day_________Are weekends different__________
Concerns about sleep____

How many hours per day of exercise_____ What types________________________________

Concerns about growth____

Development: Circle areas of concern or write below
Behavior Communication Problem Solving Social skills Gross motor or fine motor skills

____

____

____

Media Use: How many hours/day:
TV_______Computer______Cell Phone_______Video games______Tablet_______

Education:
Daycare, School or Home__________________________________ Grade level__________

Concerns____

Social History:

Who lives at home with child:

Adults ____

Children (ages) ____

____

Other ____

List care givers outside of home____

Are parents: Married Partnered Separated Divorced Never Married

Parent Occupation___________________Parent Occupation______________________

Has the child been exposed to:

Tobacco Vape Marijuana Alcohol Other drugs

Are guns in the home_____ If guns are in the home, are they stored?__________________

Has the child been exposed to violence____

Review of Systems:

Does your child have any of the following:

Fever/chills/excessive sweating	Headaches	Speech problems
Unexplained weight loss/gain	Weakness/clumsiness	Sleep problems
Cross eyes/squinting/vision issues	Muscle/joint pain/stiffness	Depression
Sneezing/allergies/itchy eyes	Hearing problems	Anxiety
Mouth breathing/snoring	Skin rashes/unusual moles	Stress
Frequent runny noses	Menstrual problems	Substance abuse
Easy Bruising/bleeding	Teeth/Mouth problems	Harmful behaviors

Any other items you feel are important for us to know about your child?

____

____

____

Name of person completing the form____

Relationship to child____

Date_____________