PEDIATRIC PATIENT HISTORY

(To be filled out by parent)

Date ___________________

Child's Name __________________________________ DOB ____________ Age _________ ❑ Male ❑ Female

Mother's Name _________________________ Maiden Name ______________ Father's Name ______________

PREGNANCY AND BIRTH

1. Mother's age at birth _______
2. Did mother have any illness during pregnancy?
   ❑ No ❑ Yes ___________________________
3. Any medications or drugs other than vitamins and iron?
   ❑ No ❑ Yes ___________________________
4. Delivery by ❑ Vaginal birth ❑ C-Section
   If C-Section, why?___________________________
5. Was the baby born at term (>37 wks)?
   ❑ Yes ❑ No ___________________________
6. Birth weight:______________ Birth length:______________
   APGAR score 1 min.____________ 5 min.____________
7. Did the baby have any problems while in the hospital?
   ❑ No ❑ Yes ___________________________
   If yes, what kind? ❑ Jaundice ❑ Infection ❑ Breathing problem
   ❑ Other:______________________

PAST MEDICAL HISTORY

1. Allergic reaction to foods, medications, insects, other? ❑ No ❑ Yes
   If yes, give name and reaction:___________________________
   ____
   ____
2. Any serious reactions to immunizations? ❑ No ❑ Yes
   If yes, which ones?___________________________
3. Any hospitalizations or surgeries? ❑ No ❑ Yes
   If yes, date and reason:___________________________
   ____
   ____
4. Any serious injuries? ❑ No ❑ Yes
   If yes, date and injury:___________________________
   ____
   ____
5. Does your child have or has she/he ever had: (If yes, please explain)
   ❑ Frequent ear infections ❑ Frequent strep throat ❑ Asthma
   ❑ Frequent abdominal pain ❑ Urinary track infections
   ❑ Pneumonia ❑ Frequent diarrhea and constipation
   ❑ Any heart problems or heart murmurs ❑ Seizures
   ❑ Eczema, hives or other skin conditions
   ❑ Anemia or bleeding problem ❑ Diabetes ❑ Chicken pox
   ❑ Vision/Hearing problems ❑ Frequent headaches
   ❑ Any other significant problems

If you answered yes to any of the above, please explain below:__________
____
____
____

FEEDING AND NUTRITION

1. How is your child's appetite? ❑ Good ❑ Fair ❑ Poor
2. Was there severe colic or any unusual feeding problems during the first three months? ❑ No ❑ Yes ___________________________
3. Was your child breast fed? ❑ No ❑ Yes If so, how long?__________
4. Which of the following foods are included in your child's daily diet?
   ❑ Whole Milk ❑ Skim Milk ❑ 2% Milk ❑ Meats
   ❑ Vegetables ❑ Juices ❑ Fruits ❑ Vitamins

DEVELOPMENT/BEHAVIOR

1. At what age did your child:
   sit alone_______ walk alone_______ toilet train_______
2. Was she/he saying words by 18 months? ❑ Yes ❑ No ____________
3. Trouble sleeping? ❑ No ❑ Yes ___________________________
4. Grade in school: ________
5. Has she/he failed or repeated a grade in school?
   ❑ No ❑ Yes ___________________________
6. Does she/he get along with other children?
   ❑ Yes ❑ No ___________________________

SAFETY/ENVIRONMENT

1. Do you live in a: ❑ Private House ❑ Apartment ❑ Mobile Home
2. Is there a working smoke alarm on each floor of the house?
   ❑ Yes ❑ No ___________________________
3. Does your child always use a car seat/belt?
   ❑ Yes ❑ No ___________________________
4. Does your child always wear a helmet when skating or bicycling?
   ❑ Yes ❑ No ___________________________
5. Any concerns about lead exposure (old home/plumbing/peeling paint)?
   ❑ No ❑ Yes ___________________________
6. Are there smokers the child is exposed to?
   ❑ No ❑ Yes ___________________________
7. Are there guns in the home? ❑ No ❑ Yes
   If yes, is it securely locked? ❑ Yes ❑ No
8. Are there any pets at home? ❑ No ❑ Yes ______________
9. Primary drinking water supply (including water used to mix formula):
   ❑ Well ❑ City ❑ Bottled

FAMILY HISTORY/SOCIAL HISTORY

1. Please list all people living in the child's home:

Name	Age	Relationship to Child	Health Problems

2. Are your child's parents:
   ❑ married ❑ unmarried ❑ separated ❑ divorced
3. Father's Occupation:___________________________
   Father's Employer:___________________________
4. Mother's Occupation:___________________________
   Mother's Employer:___________________________
5. Child care situation: ❑ parents
   ❑ others (specify who and hours per day) ______________
6. Check if a family member has had any of the following:
   ❑ Asthma ❑ Diabetes on insulin ❑ Diabetes not on insulin
   ❑ Seizures or epilepsy ❑ Immunodeficiency ❑ Mental Retardation
   ❑ Bleeding disorder ❑ Deafness ❑ Alcohol and/or drug abuse
   ❑ Kidney disease ❑ Heart disease (before 50 yrs old) ❑ Anemia
   ❑ High blood pressure (before 50 yrs old) ❑ Tuberculosis
   ❑ Liver disease ❑ Other______________________

If you answered yes to any of the above, please explain below:__________
____