Patient History

Date: _____

CHILD'S NAME: _____

DATE OF BIRTH: _____ SEX : _____

REFERRED BY: _____ PREVIOUS PEDIATRICIAN: _____

PRENATAL HISTORY

Did mother have any infectious illness during the pregnancy? (For example: German measles (rubella), flu, bladder or kidney infection)

Type of infection: _____ Month of pregnancy: _____

Medication given: _____

Did mother take any medications during pregnancy?

_____ Vitamins _____ Laxatives _____ Iron _____ Antibiotics _____X -Rays

_____ Aspirin/Tylenol _____ Prescriptions _____ Cigarettes _____ Alcoholic Beverages

_____ Birth Control Pills _____ Other over-the-counter drugs _____ Marijuana or other drugs

Were there any complications of the pregnancy? (such as diabetes, thyroid disease, toxemia, excessive bleeding) _____

Were there any complications of the labor or delivery? (such as prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breath) _____

Birth weight: _____ Length: _____ Did the infant stay longer than the mother? _____

If so, why?: _____

HOSPITAL OF BIRTH (Name, City, State)

_____

_____

OBSTETRICIAN AND ADDRESS

_____

_____

ILLNESSES

Have there been any hospitalizations?	_____ Yes	_____ No
Have there been any major medical problems?	_____ Yes	_____ No
Any "childhood" illnesses? (such as chickenpox, measles, etc.)	_____ Yes	_____ No
Fracture or other injury?	_____ Yes	_____ No

If yes, please explain: _____

_____

PUBERTY

Any signs of breast development, adult body odor, voice change, adult hair patterns, periods? ___Yes ___No

MEDICATIONS

_____

_____

_____

ALLERGIES

_____

_____

_____

DIET

_____

_____

Patient Name: _____ Dateof Birth: _____

Father (biological): _____ Age: _____

Mother (biological): _____ Age: _____

Medical Problems: _____

Siblings:

Name: _____ Age: _____

Medical Problems: _____

Name: _____ Age: _____

Medical Problems: _____

Name: _____ Age: _____

Medical Problems: _____

Name: _____ Age: _____

Medical Problems: _____

Medical conditions in biological aunts, uncles, cousins or grandparents: Please circle or write in:

SKIN: eczema, psoriasis, ichthyosis, other: _____

EYES: blindness, cataracts, lazy eye, other: _____

EARS: deafness, ear infections, deformities, other: _____

NOSE/THROAT: sinus problems, lack of sense of smell, tonsillitis, other: _____

MOUTH: cleft palate, cleft lip, other: _____

GLANDS: thyroid trouble, diabetes (adult), diabetes (juvenile), other: _____

LUNGS: asthma, cystic fibrosis, other: _____

HEART: murmurs, heart attacks, congenital abnormalities, high blood pressure, other: _____

_____

STOMACH/BOWEL: ulcers, colitis, lactose intolerance, other: _____

KIDNEY/BLADDER: congenital abnormalities, infections, kidney stones, other: _____

_____

BONE OR JOINT DISEASE: osteoarthritis, rheumatoid arthritis, osteogenesis imperfecta, other : _____

_____

NEUROLOGICAL PROBLEMS: seizures, paralysis, strokes, other: _____

_____

CANCER: _____

DEVELOPMENT PROBLEMS: _____

PSYCHIATRIC CONDITIONS: manic depressive (bipolar) disorder, schizophrenia, other: _____

_____

OTHER: _____

_____

CHILD'S NAME: _____
Last Name First Name Middle Initial

DEVELOPMENT: _____

Please try to estimate the age at which your child could do the following things:

Sat alone: _____ Walked Alone _____ Spoke first word _____ Several word _____

SCHOOL PERFORMANCE:

Who lives at home? _____ Does mother work? _____

Preschool or Daycare? _____ Name preschool, childcare: _____

Who cares for child/children while parent(s) is/are at work? _____

REVIEW OF SYSTEMS:

Has your child had any of the problems listed in the family history (separate page)? _____ Yes _____ No

Has she/he had frequent problems with:

_____ Head: Headaches, dizziness, injury, other _____

_____ Eyes: Vision problems, infection, pain, other _____

_____ Ears: Hearing problems infections, pain, other _____

_____ Nose: Frequent stuffiness, easy bleeding, other _____

_____ Mouth: Tooth decay, poor bite, other _____

_____ Throat: Frequent sore throat, trouble with swallowing, other _____

_____ Neck: Stiffness, swelling, swollen glands, other _____

_____ Chest: Deformity, pneumonia, cough, asthma, other _____

_____ Heart: Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other _____

_____

_____ Abdomen: Vomiting, frequent pain, diarrhea, constipation, other _____

_____ Urinary: Pain on voiding, voiding frequently, bed wetting, other _____

_____ Skin: Rash, infection, other _____

_____ Neurological: Development problems, seizures, meningitis, other _____

_____ Endocrine: Weight gain or loss, intolerance to heat/cold, thirst, hair changes such as thinning or falling out, other _____

_____ Arms & Legs: Deformity, abnormal walking, joint pain, joint swelling, other _____

_____ Hematological: Anemia, abnormal bleeding, other: _____

If yes to any of the above, please explain: _____

_____

_____

Are there specific problems you wish to discuss today? If so, please explain: _____

_____

_____