

## PEDIATRIC PATIENT HISTORY

Child's Name \_\_\_\_\_ Age Today \_\_\_\_\_ Date \_\_\_\_\_  
 Previous Physician \_\_\_\_\_ Referred By \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Hospital \_\_\_\_\_ Birth weight \_\_\_\_\_ Length \_\_\_\_\_  
 Prenatal Problems Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes" please list \_\_\_\_\_

Full-Term or Premature \_\_\_\_\_

Type of Delivery Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_

Problems after Birth or During First Week ( 0 = None)

Breathing Problems \_\_\_\_\_  
 Convulsions \_\_\_\_\_  
 Jaundice If "Yes" was treatment needed \_\_\_\_\_  
 Feeding Problems \_\_\_\_\_  
 Others \_\_\_\_\_  
 Breast Fed (How Long) \_\_\_\_\_  
 Bottle Fed (Type(s) of Formula) \_\_\_\_\_

### FAMILY

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_ Occupation \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_ Occupation \_\_\_\_\_  
 Brother's \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_  
 Brother's \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_  
 Brother's \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_  
 Sister \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_  
 Sister \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_  
 Sister \_\_\_\_\_ Age \_\_\_\_\_ Health \_\_\_\_\_

Parents Marital Status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Never Married \_\_\_\_\_ Separated \_\_\_\_\_  
 Residence: City Name \_\_\_\_\_ House \_\_\_\_\_ Apartment \_\_\_\_\_ Flat \_\_\_\_\_ Mobile Home \_\_\_\_\_  
 Child's School \_\_\_\_\_ Grade \_\_\_\_\_ Grades : Above Average \_\_\_\_\_ Average \_\_\_\_\_ Poor \_\_\_\_\_  
 Preschoolers: In Day Care Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes # of days per week \_\_\_\_\_  
 Name of Sitter/School \_\_\_\_\_

### IMMUNIZATIONS (LIST DATES (S) )

D.P.T./D.T./t.d. ....
Oral Polio .....
M.M.R. ....
H.I.B. ....
TB tine .....
Hemoglobin .....
Urinalysis .....
Other .....


Allergies \_\_\_\_\_ Current Medications \_\_\_\_\_

**PAST-HISTORY**

**DISEASES (S) (0 = None)**

Rosella ("Baby Measles") \_\_\_\_\_  
Rubella ("German or 3-day measles") \_\_\_\_\_  
Rubeola ("Hard or 7-day Measles") \_\_\_\_\_  
Mononucleosis \_\_\_\_\_  
Pneumonia \_\_\_\_\_  
Bladder infection \_\_\_\_\_  
Heart murmur \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Fainting \_\_\_\_\_  
Bowel problems \_\_\_\_\_  
Menstrual problems \_\_\_\_\_  
Fracture \_\_\_\_\_  
Other \_\_\_\_\_

Mumps \_\_\_\_\_  
Chickenpox \_\_\_\_\_  
Scarlet Fever \_\_\_\_\_  
Strep throat \_\_\_\_\_  
Ear infection \_\_\_\_\_  
"Wheezing" or Asthma \_\_\_\_\_  
Seizures \_\_\_\_\_  
Hives/Skin problems \_\_\_\_\_  
Bed-wetting \_\_\_\_\_  
Behavior problems \_\_\_\_\_  
Age of first period \_\_\_\_\_  
Sutures \_\_\_\_\_

Previous Hospitalizations/ER Visits:

Give name of Hospital, Type of problem. Child's age. If none please write none.

**FAMILY HISTORY**

**Medical Problems (Relatives of the Patient)**

0 = None                      GP = Grandparent  
M = Mother                  A/U = Aunt/Uncle  
F = Father                    GGP = Great-Grandparent  
S/B = Sister/Brother

Tuberculosis (T.B.) .....  
Allergy/asthma .....  
Heart Attack Before age 40 .....  
Diabetes .....  
Hypoglycemia (Low Blood Sugar) ...  
Convulsions .....  
Heart Disorder .....  
Cancer .....  
Hypertension (High Blood Pressure)  
Arthritis .....  
Kidney/Bladder Disorder .....  
Stroke .....  
Bleeding Disorder .....  
Muscle Disorder .....  
Other .....

0	M	F	S/B	G	A/U	GGP	

History of birth defects \_\_\_\_\_

History of S.I.D.S. \_\_\_\_\_

Signature of Informant \_\_\_\_\_

Date \_\_\_\_\_