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PEDIATRIC MEDICAL HISTORY

Today's Date: _____

Dear Parents: Welcome. Please fill in as much of this form as you can. It will help me learn more about your child, and provide a better examination.

Child's Name: _____ Birth Date: _____ Age: _____

Parent's Name: _____ Birth Place: _____ Sex: M F

List all people living at home and their ages:

1. What is the main reason for your child's visit today? _____

2. If your child is not well, or has a problem, when were you first aware of this? _____

3. Other things you would like to talk about: _____

4. Has your child taken any MEDICATIONS during the past month () Yes () No

Give name(s) if known: _____

5. Would you like to talk about your child while he/she is () In the room? () Out of the room? () Doesn't matter.

6. Symptoms or terms that apply to your child now (Please Circle):

GENERAL:	Healthy, sick, active, fever, pale, tires easily.
RESPIRATORY:	Runny nose, stuffy nose, mouth breathing, ear trouble, cough, Wheezing
DIGESTIVE:	Stomach, nausea, vomiting, constipation, diarrhea, does not eat properly.
URINARY:	Burning, straining, bad odor to urine, diaper rash, bed wetting.

BEHAVIORAL & MISC. Pleasure to you, happy, fussy, sleeps well, sleep problem, hard to manage, irritable, spoiled, temper tantrums, headache, skin rashes, eye or vision problems, speech problem, bad teeth, school problem.

7. How is discipline handled? _____

8. Diet: Any specific considerations? _____

Is your child's appetite () good, () fair, () poor?

Is your child taking Vitamins? () Yes () No; Iron? () Yes () No; Flouride () Yes () No

IMMUNIZATIONS AND TESTS: Are Immunizations up to date? () Yes () No

PAST HISTORY: Pregnancy, Labor, Birth, and First Week of Life

Did you experience any unusual illness or complications of pregnancy? () Yes () No

Did you smoke during your pregnancy? () Yes () No Breast Fed? _____ How long? _____

List any medications or drugs you took during your pregnancy: _____

Did you deliver () Early, () Near Due Date, () Late? Hours of active labor _____ Ease of Delivery () Yes () No

Birth Weight _____ lbs. _____ oz. Birth Length: _____ inches

Did your baby have trouble during the first week of life () Yes () No. If yes circle terms: Blue spells, jaundice, breathing problems, required oxygen, infection, transfusion, birth defect, drugs used, other: _____

Illnesses, Allergies, and Other problems:

Has your child experienced an unusual number of illnesses or other health problems requiring medical care? () Yes () No

Circle appropriate terms: excessive colic, feeding problems, ear trouble, frequent colds, wheezing, hoarseness, serious falls, surgical operations, convulsions, drug

reactions, foot or leg problems, urinary infections, behavior problems, persistent skin rashes,

Has your child ever been hospitalized () Yes () No. If yes, state why, where and when:

Does your child suffer from ALLERGIES of any kind? () Yes () No

Caused by: _____ Symptoms: _____

Have you thought of him/her as being a nervous child? () Yes () No

DEVELOPMENT: So far as you know, is your child's development normal? () Yes () No

When did he/she: Roll over _____ Sit alone _____ Stand Alone _____

Take 10 steps alone _____ Say 20 words you could understand _____

FAMILY HISTORY

Is this child's father living? () Yes () No. Age: _____ Height: _____
In good health? () Yes () No. Last grade of school finished: _____

Is the child's mother living? () Yes () No. Age: _____ Height: _____
In good health? () Yes () No. Last grade of school finished: _____

Are your other children in good health? () Yes () No. Comments: _____

Are there significant family or marital problems? _____

Family religion preference _____

Are there significant problems in housing, income, sleeping arrangement for this child?
() Yes () No.

Parent's occupation: father _____ mother _____

Do the adults in the family usually agree on the rearing of the child? () Yes () No

Any other comments: