



Pediatric Patient History

Date: _____
 Patient's name: _____ Patient's Date of Birth: _____
 Patient's school and current grade (or daycare): _____
 Previous Health Care Provider: _____
 Referred to by: _____

Pregnancy and Birth

Mother's age when patient was born: _____ **Baby's diet:**
 Any illness during pregnancy: _____ during the 1st six months: Breast Bottle
 Medications (other than vitamins/iron): _____ If bottle, what formula? _____
 Patient's birth weight: _____ Is children on any special diet? _____
 Delivery (circle one): Vaginal C-Section Does child take vitamins?: Yes No
 Herbal supplements?: Yes No
 Fluoride?: Yes No
 Did baby go home within a couple of days with mom? Yes No
 If no, please explain: _____

Past Medical History

Date and place of last check: _____ Chronic illnesses: Yes No
 Allergies to medication: Yes No Reactions to food or insects: Yes No
 Any hospitalizations?: Yes No Any surgeries?: Yes No
 Any medications taken regularly?: Yes No
 If yes, please explain: _____

Family (not patient) History:

Age and General Health of Mom _____
 Dad _____

Circle any diseases that the patient's parents, grandparents
 Brothers, sisters, aunts or uncles have had:

- | | | |
|-----------|------------------|-----------------------|
| Anemia | Asthma | Learning difficulties |
| Diabetes | Cancer | Bowel Problems |
| Seizures | Depression | Heart Trouble |
| Allergies | ADHD | High Blood Pressure |
| AIDS | Drug Problems | |
| Autism | Tuberculosis | |
| UTI's | Alcohol problems | |

Siblings Name & Date of Birth:

Please list any additional medical problems: _____

Review of Systems (patient):

Has patient ever had any of the following:

Frequent ear infection:	Yes	No
Eye problems:	Yes	No
Asthma:	Yes	No
Allergies:	Yes	No
Heart murmur/problem:	Yes	No
Urinary tract infection	Yes	No
Chronic cough:	Yes	No
Chronic diarrhea:	Yes	No
Constipation	Yes	No
Seizures:	Yes	No
Hearing problems:	Yes	No
Eczema/skin problems:	Yes	No
Anemia or Sickle Cell Trait:	Yes	No
Developmental delays:	Yes	No
Speech delay:	Yes	No
Sleeping problems:	Yes	No
School problems:	Yes	No
ADHD:	Yes	No
Hyperactivity:	Yes	No
Bed wetting:	Yes	No
Discipline problems:	Yes	No

Name: _____
DOB: _____

Reviewed _____ / _____	Reviewed _____ / _____
Date/Initials	Date/Initials
Reviewed _____ / _____	Reviewed _____ / _____
Date/Initials	Date/Initials



7. Do you have a parent, brother or sister with a history of the following:

- a. Cancer of the breast, intestine or female organs
b. Heart pain or heart attacks before the age of 55

If yes to a or b:
Relation: Type:
Relation: Type:

8. Osteoporosis (thin-bone) screening:

- a. Is there a history of any relatives with the following: stooping over or losing height as they got older, "thin bones," hip fractures
If yes, relation:

- b. Have you had any of the following: Height loss, Broken hip or wrist, Bone-density test, Have you ever had any abnormal mammograms?

If yes, date: problem:
For abnormality, did you have any of the following:

- Biopsy
Cyst fluid drained
Surgery

- c. Do you take any of the following: Steroids (prednisone), Medication for thyroid, seizures or or thin bones

9. Have you ever used tobacco?
If yes:

Average number of packs/day:
Number of years smoked:
Year quit:
When are you planning to quit?
now next 6 months sometime never

10. Do you drink alcohol?
If yes:

- a. Have you ever felt you should cut down on your drinking?
b. Have people ever annoyed you by nagging you about your drinking?

c. Have you ever felt guilty about your drinking?
d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

11. Prevention:

- a.
b. Exercise: Activity, Days per week, Time/duration, Exertion: stroll mild heavy
c. Do you always wear seat belts?
d. If over 30 years old, have you had your cholesterol level checked in the past five years?
e. Have you had a tetanus shot in the past 10 years?
f. Does your house have a working smoke detector?
g. Do you have firearms at home?
h. Have you ever had a mammogram?
i. How many sexual partners have you had in the last 12 months? In your lifetime?
j. When is the last time you had a dental check-up?

12. Please describe any concerns you have:

Blank lines for describing concerns.

Thank you for your help.

Name:
DOB: