Pediatric/Adolescent History

Name________________________________DOB_______________Age_________ Male Female

Pregnancy

Were there any problems with pregnancy & delivery of this child? Yes No

If yes please explain____

Birth

Term of premature?____

Type of delivery: Vaginal C-Section

Length:________________ Weight:_______________________________

Problems: Jaundice Respiratory distress Feeding problem Rashes Breech Diabetes

Explain:____

____

Hospitalizations

Hospital Reason

___________________ ______________________________________ 20_______

___________________ ______________________________________ 20_______

___________________ ______________________________________ 20_______

___________________ ______________________________________ 20_______

Illness

Check if child has, or has had:

Anemia
Asthma
Chicken pox
Cigarette
Depression
Drug/Alcohol
Ear Problem
Eczema (Skin rash)
Epilepsy
Eye Problem
Kidney/bladder problem
Liver disease/jaundice
Rheumatic fever
Tuberculosis
Other______________________

____

Developmental Milestones

At what age did your child do the following?

☺ Sit with support?______________________ ☺ First walk?____________

☺ Say first words?______________________

☺ Toilet trained? Urine_______________ Stool_________________

Medications

List any medications child is taking:

____

____

____

____

Allergies

List any allergies:

____

____

____

____

Immunizations

Are the child's immunizations to date?

Yes No

FAMILY HISTORY

PLEASE CHECK ALL THAT APPLY	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS
HEART DISEASE					
HIGH BLOOD PRESSURE					
STROKE					
CANCER					
GLAUCOMA					
DIABETES					
EPILEPSY					
BLEEDING DISORDERS					
KIDNEY DISEASE					
THYROID DISEASE					
MENTAL ILLNESS					
PARKINSON'S DISEASE					
ALZHEIMER DISEASE					
OTHER:					

Social & Environmental History

Who does the child live with?______________________________

Does the child wear a bike helmet?__________________________

Is the child in school or day care?__________________________

Is the child adopted?___________________________

Are there smoke detectors in the home?____________

Is the home tobacco free?________________________

If there is a gun in the home, is it out of child's reach?_____________________ If yes, is it out of reach? ________________

Parent Signature____ Date_______________________

Physician Signature____ Date_______________________

3-2004:bcv:pedhx