

NEW PEDIATRIC PATIENT HISTORY AND REVIEW

(To be filled out by the parent)

Mother's name: _____ Age: _____ Occupation: _____

Father's name: _____ Age: _____ Occupation: _____

Who referred you to our practice? _____

PREGNANCY AND BIRTH HISTORY:

1. Mother's age at birth _____
2. Any complications/infections during pregnancy? No Yes
If "yes," describe _____
3. Any medications during pregnancy? No Yes
If "yes," list _____
4. Where was the baby delivered? _____
5. Was the baby on time? No Yes
6. What was the birth weight? _____
7. What was the birth length? _____
8. Did the baby have difficulty starting to breathe? No Yes
9. Any problems in the first 3 months of life? No Yes
If "yes," list _____
10. Passed hearing screen? No Yes
11. Hepatitis B vaccination given at the hospital? No Yes

PAST MEDICAL/SURGICAL HISTORY:

1. Where has your child gone for health care?

2. Reason for change? _____
3. Date of last checkup? _____
4. Any hospitalizations or surgeries since birth? No Yes
If "yes," list _____
5. Any serious injuries? No Yes
If "yes," list _____
6. Any history of frequent infections? No Yes
If "yes," list _____
7. Any medications taken regularly? No Yes
If "yes," list _____
8. Has your child had any allergic reactions to any foods, medications, or insect bites? No Yes
If "yes," describe _____
9. List any other health problems _____
10. Does your child have a record of immunizations? No Yes

FAMILY HISTORY: Please list immediate family members with a history of any of the following:

Anemia _____	Hepatitis _____
Asthma _____	GI problems _____
Allergies _____	High cholesterol _____
Diabetes _____	Skin problems _____
Obesity _____	Alcoholism _____
Blood problems _____	Arthritis _____
Lung problems _____	TB _____
High blood pressure _____	Seizures _____
Heart disease _____	Migraines _____
Mental retardation _____	Stroke _____
Kidney problems _____	Cancer _____
Thyroid problems _____	Other _____

SOCIAL HISTORY:

1. Parental marital status: please circle
Married/Separated/Divorced/Widowed/Single parent
2. Sibling name(s) and age(s): _____
3. Who lives at home? _____
4. Does anyone at home smoke or is the child exposed to smoke? No Yes
5. Type of home: house/apt/mobile home/other
6. Water supply: city water/well water
7. Any pets? No Yes
If "yes," indoor/outdoor? Type of pet(s)

8. Describe childcare outside of the home: _____
9. Name of child's school and grade: _____
10. Child's hobbies: _____

FEEDING AND NUTRITION:

1. For the first six months, breast or bottle fed?
If bottle, which formula? _____
2. Any feeding problems? No Yes
3. Does child take vitamins? No Yes
If "yes," list _____
4. Is your child's appetite usually good? No Yes

DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did he/she say any words at age 18 months? No Yes
4. How does your child compare to others of his/her own age? Below average/average/above average
5. Does he/she get along with other children? No Yes
6. Does he/she get in trouble at school? No Yes
7. Circle if your child has any of the following:
speech problems nail biting
discipline problems bad temper
thumb sucking > 4 years bed wetting
toilet training problems hyperactivity

SAFETY/ENVIRONMENT:

1. Is your hot water heater set at 120 degrees? No Yes
2. Are there home smoke alarms on each floor? No Yes
3. Is there a fire extinguisher in the house? No Yes
4. Are there any fire arms in the house? No Yes
If "yes," are they unloaded/locked storage? No Yes
5. Does your child always wear a safety restraint in the car? No Yes
6. Does your child always wear a helmet when riding a bike or skating? No Yes

Patient Name: _____

Date of Birth: _____

Date of Exam: _____