

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: _____