Pediatric History

Practice Name: ______________________ Date of Entry: ______________
Patient Name: ______________________ Date of Birth: ______________
Address: ______________________ Phone No.: ______________
______________________ Emergency No.: ______________
Source of Information: ______________________ Relationship: ______________

Mother's Pregnancy/Child's Birth History: (under 2 yrs old)

Illness during pregnancy?	NO	YES
Any medications during pregnancy?	NO	YES
Alcohol/Drug Abuse	NO	YES
Problems at birth?	NO	YES

Describe: ______________________

Type of Delivery? Vaginal C-Section

Birth Weight: __________ Discharge Weight: __________

Did baby receive Hepatitis B vaccine?	NO	YES

Date of Hepatitis B vaccine: ______________

Name of Hospital: ______________

Was first PKU done?	NO	YES

Patient's Health History: Has your child ever had:

Measles/Mumps/Chicken Pox	NO	YES
Frequent ear infections	NO	YES
Vision/Hearing Problems	NO	YES
Skin Problems	NO	YES
Asthma/Allergies	NO	YES
TB/Lung Disease/Croup	NO	YES
Seizures/Epilepsy	NO	YES
High Blood Pressure	NO	YES
Heart Defects/Disease	NO	YES
Liver Disease/Hepatitis	NO	YES
Diabetes	NO	YES
Kidney Disease/Bladder Infections	NO	Yes
Handicaps/Disabilities	NO	YES
Bleeding Disorders/Hemophilia	NO	YES
Sexually Transmitted Diseases	NO	YES
Emotional Problems/Suicide Attempts	NO	YES
Hospitalizations/Surgeries	NO	YES
Physical/Emotional Abuse/Broken Bones	NO	YES
Immunizations Up-To-Date	NO	YES

Psycho-Social History:

How many living in the household? ______________

Who cares for the child? ______________

Are parents working: NO YES

Name of school: ______________

Grade: ______________

Family History: Has anyone in the family (parents, grandparents, aunts & uncles, sisters & brothers, cousins, etc.) had the following: Who:

			Who
TB/Lung Disease	NO	YES	______
HIV/AIDS	NO	YES	______
Suicide Attempts	NO	YES	______
Heart Disease	NO	YES	______
High Blood Pressure	NO	YES	______
High Cholesterol	NO	YES	______
Blood Disorders	NO	YES	______
Diabetes	NO	YES	______
Seizures	NO	YES	______
Allergies/Asthma	NO	YES	______
Mental Retardation	NO	YES	______
Mental Illness	NO	YES	______
Cancer	NO	YES	______
Birth Defects	NO	YES	______
Hearing/Speech Problems	NO	YES	______
Kidney Disease	NO	YES	______
Alcohol/Drug Abuse	NO	YES	______
Stroke	NO	YES	______
Hepatitis/Liver Disease	NO	YES	______
Thyroid Disease	NO	YES	______
Learning Problems	NO	YES	______
Attention Deficit Disorder	NO	YES	______
Family Violence	NO	YES	______

Adolescent History: (Interview separately)

Age at first period ______ LMP ______________

Sexually Active NO YES # of partners ___

Sex of partners MALE FEMALE

Any fears of partner/other violence? NO YES

Smoker: NO YES Alcohol Use: NO YES

Drug Use: NO YES Working: NO YES

Do you think about hurting yourself? NO YES

Access to gun/weapon: NO YES

Behavior problems: ______________________________
____

Comments: ______________________________