Patient Name:_____
DOB:_____
Date:_____

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Pediatrics**

<u>Allergies</u>: (Include name of medication or food, reaction, and age of onset)
_____
_____

<u>Current Problems:</u>
_____
_____

<u>History:</u>

<u>Birth History:</u>

Birth Length: _____   Birth Weight:_____   Birth Head Circumference:_____
Discharge Weight: _____   Gestational Age at Birth (weeks):_____   Delivery Method: Vaginal   C-section
                                                                        If C-section, why? _____

APGAR scores: 1 min _____   5 min _____   10 min _____   Infant Feeding: Breast   Bottle   Both
                                                                        Formula name: _____

Hearing Screening: Pass   Fail   Re-testing   Heart disease screening: Pass   Fail

<u>Medical History:</u> (Check any that have been diagnosed and comment below)

____Hospitalizations?	____Prematurity	____Diabetes
____Asthma	____GE Reflux	____Vision problems
____Allergic Rhinitis	____Constipation	____Developmental Delay
____Eczema	____Anemia	____Seizures
____Wheezing	____Recurrent Ear infections	____ADD/ADHD
____Food Allergies	____Recurrent Strep	____Mental Illness
____Murmur	____Urinary Tract Infection (UTI)	____Substance Abuse
____Congenital Heart Disease	____Vesicoureteral Reflux (VUR)	

Other Medical History: _____
_____

<u>Surgical History:</u>   _____**No Surgeries**
 (Check any past surgeries and complete age/date and surgeon if known)

Procedure	Date or Age	Surgeon
Adenoidectomy		
Appendectomy		
Ear Tubes		
Fundoplication		
Gastrostomy Tube Placement		
Heart Surgery		
Hernia Repair		
Orthopedic Surgery		
Tonsillectomy		
Urological Surgery		
VP Shunt		

Other Surgical History: _____
_____

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Family History: (Check any known problems in the family – please complete *at least* for parents and siblings)

Relationship to CHILD		Name	Alive?	No Known Problems	ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	MentalIllness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		Y N																			
	Father		Y N																			
Siblings	Bro Sis		Y N																			
	Bro Sis		Y N																			
	Bro Sis		Y N																			
	Bro Sis		Y N																			
	Bro Sis		Y N																			
Grandparents	MGM		Y N																			
	MGF		Y N																			
	PGM		Y N																			
	PGF		Y N																			

Comments (including *Other* responses): _____
_____

Relationships: P=Paternal (father's side of family), M=Maternal (mother's side of family), GM=Grandmother, GF=Grandfather
For example: MGM = Maternal Grandmother

Additional Family History (if needed)

Relationship to CHILD	Name	Alive?	No Known Problems	ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	MentalIllness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
		Y N																			
		Y N																			
		Y N																			
		Y N																			
		Y N																			
		Y N																			

Home Environment:
Number of People at Home: _____
Lives with biological parents: Yes   No
Foster Care: Yes   No
Primary Care Givers (circle):   Parents   Daycare   Relatives   Others:_____
Daycare (hours/day):   _____
Time at Relatives (hours/day):   _____
Pets: Yes   No

Parent's Status: Married   Divorced   Single   Other_____
Mother's Occupation: _____   Father's Occupation: _____