Pediatric/Adolescent History

Name ____________________________________ DOB________________ Male___Female____

Pregnancy

Were there any problems with pregnancy & delivery of this child? ____Yes ____No
If yes please Explain____
____
____

Birth

Circle One: Term or Premature
Circle One: Type of delivery: Vaginal or C-section
Length: ______________ Weight: ________________
Problems: _____Jaundice _____Respiratory distress _____Feeding problem _____Rashes _____Breech
Other ____
____

Hospitalizations/Operations

Name of Hospital	Reason	YEAR
________________________	_____________________________	_____
________________________	_____________________________	_____
________________________	_____________________________	_____
________________________	_____________________________	_____

Developmental Milestones

At what age did your child do the following?
*Sit with support? _____________ *Say first words? _____________
*First walk? _____________ *Toilet trained? _____________

Medications
List any medications child is taking:
____
____
____
____

Allergies
List any allergies:
____
____
____
____

Please bring an up to date copy of your child's immunizations.

Immunizations Are the child's immunizations up to date? _____ Yes _____ No

Illnesses Check if child has, or has had:

_____Anemia _____Asthma _____Chicken pox _____Diabetes
_____Diarrhea (Chronic) _____Ear problem _____Epilepsy
_____Eye problem _____Kidney/Bladder Problems _____Liver disease
_____Jaundice _____Rheumatic fever _____Eczema (Skin rash) _____Tuberculosis

Other ____
____
____

Family History

Please check all that apply	Father	Mother	Sibling's
Heart Disease			
High Blood Pressure			
Stroke			
Cancer			
Glaucoma			
Diabetes			
Epilepsy			
Bleeding disorder			
Kidney disease			
Thyroid disease			
Mental illness			
Other			

Social & Environmental History

Who does the child live with? _________________________________

Is the child adopted? Y or N

Does the child wear a bike helmet? Y or N

Are there smoke detectors in the home? Y or N

Is the home tobacco free? Y or N

Does the child use a seat belt/car seat? Y or N

Is the child in school or day care? _______________________________

If there is a gun in the home, is it out of children’s reach? ___________

Parent signature____ Date_______________________________

Physician signature____ Date_______________________________