Initial History (Pediatric)

Name of Patient _____ Sex: ___Male ___Female DoB ___ /___ /___

Form Completed by _____ Relation to patient _____ Date ___ /___ /___

Family

Are mother and father ☐ married ☐ separated / divorced ☐ other?

If separated / divorced, what is the patient's custody status? _____

If one or both parents are not living in the home, how often does child see that parent(s)? _____

Are there siblings living away from home? ☐ Yes ☐ No

If yes, give name, age and where they live: _____

List all family members living in the patient's home

Name	Relation	Birth Date	Health Problems
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ / ___ /	

Current Medical History

Are immunizations up to date? ☐ Yes ☐ No

Is your child having any medical problems? ☐ Yes ☐ No _____

Do you consider your child to be in good health? ☐ Yes ☐ No _____

Current Medications: _____

Drug Allergies? ☐ Yes ☐ No _____

Review of Systems and Past Medical History

Does the patient have or has ever had any of the following:	Yes	No	*Explain*
1. a serious medical problem?	☐	☐	
2. been hospitalized or had surgery?	☐	☐	
3. had a serious injury or accident?	☐	☐	
4. chickenpox? When? _____	☐	☐	
5. allergies, asthma, bronchitis, respiratory infections?	☐	☐	
6. repeated ear infections, tubes, difficulty with hearing?	☐	☐	
7. problems with eyes or vision?	☐	☐	
8. heart problems or a heart murmur?	☐	☐	
9. anemia, bleeding problems or blood transfusion?	☐	☐	
10. abdominal pain, constipation requiring doctor visits?	☐	☐	
11. recurrent vomiting, recurrent diarrhea, blood in stools?	☐	☐	
12. bladder or kidney infections, bed-wetting after 5 yrs.?	☐	☐	
13. recurrent skin problems (acne, eczema, etc)?	☐	☐	
14. headaches, convulsions, other neurologic problems?	☐	☐	
15. diabetes, thyroid or other endocrine problems?	☐	☐	
16. If female, has she started her menstrual periods?	☐	☐	
If yes, LMP ____/____/____			
Any problems? _____	☐	☐	

History Update *(date / initial) Changes in history noted in chart on day of update.*

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

Name of Patient_____ Date __/__/__ Chart #_____

Development *Are you concerned about the patient's...*

	Yes	No	
1. physical development?	☐	☐	_____
2. mental or emotional development?	☐	☐	_____
3. learning ability?	☐	☐	_____
4. attention span or activity level?	☐	☐	_____

If in school, has the patient had...

1. tutoring outside of the classroom?	☐	☐	_____
2. placement in a special or resource class?	☐	☐	_____
3. to repeat a grade?	☐	☐	_____
4. educational or psychological testing?	☐	☐	_____
5. behavioral problems?	☐	☐	_____

Maternal and Newborn History

Pregnancy *Check if the mother had any of the following problems:*

☐ excessive wt. gain ☐ urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ venereal disease ☐ other ☐ none

_____

_____

Did the mother smoke, use drugs or alcohol during pregnacy? ☐ Yes ☐ No

Birth

Birth Weight _____ Length _____ Apgar _____ Was baby born at: ☐ Term ☐ Early ☐ Late

If early, how many weeks gestation? _____ Was labor difficult or prolonged? ☐ Yes ☐ No

Was delivery difficult or complicated? ☐ Yes ☐ No _____

_____

_____

Newborn *Check if the patient had any of the following problems:*

☐ feeding problems: ☐ Breast _____ ☐ Formula _____

☐ slow weight gain ☐ multiple formula changes ☐ colic ☐ jaundice ☐ recurring vomiting ☐ recurring diarrhea

☐ blood in stools ☐ other ☐ none _____

_____

Family History

If a family member has or has had any of the following problems, check the appropriate box and list the family member:
M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

1. ☐ _____ Allergies
2. ☐ _____ Anemia / Blood disorders
3. ☐ _____ Arthritis
4. ☐ _____ Asthma
5. ☐ _____ Birth defects
6. ☐ _____ Bladder / Kidney
7. ☐ _____ Cancer
8. ☐ _____ Deafness
9. ☐ _____ Diabetes before 50 yrs
10. ☐ _____ Drug / Alcohol abuse
11. ☐ _____ Drug allergies
12. ☐ _____ Ear infections / tubes
13. ☐ _____ Eczema
14. ☐ _____ Emotional / Behavioral
15. ☐ _____ Epilepsy or convulsions
16. ☐ _____ Eye or visual problems
17. ☐ _____ Heart attack / stroke before 50 yrs
18. ☐ _____ Heart problems, other
19. ☐ _____ Hereditary problems
20. ☐ _____ High blood pressure before 50 yrs
21. ☐ _____ High cholesterol
22. ☐ _____ Immunity problems / HIV
23. ☐ _____ Learning prob. / Attent. span
24. ☐ _____ Liver disease
25. ☐ _____ Mental illness
26. ☐ _____ Mental retardation
27. ☐ _____ Migraine Headaches
28. ☐ _____ Obesity
29. ☐ _____ Respiratory infections
30. ☐ _____ Stomach / GI
31. ☐ _____ Thyroid or other endocrine prob.
32. ☐ _____ Tuberculosis
33. ☐ _____ Other

Provider Comments

History Reviewed by_____