



PEDIATRIC PATIENT HISTORY

PATIENT INFORMATION

Name: _____ Date of birth: _____

Phone number: _____

Allergies: _____

Parent/Guardian Name: _____ Occupation: _____

Relationship to patient: _____

Parent/Guardian Name: _____ Occupation: _____

Relationship to patient: _____

Is child adopted? Yes No

Interpreter needed? Yes No _____

PAST MEDICAL HISTORY

Prenatal History

Mode of delivery: Vaginal Primary C/S-Labored Vacuum Primary C/S-No labor Forceps Repeat C/S

Birth weight: _____ Gestation: _____

Complications with Pregnancy/Delivery: _____

Newborn Metabolic Screen results: Normal Abnormal

Hearing Screen results: Pass Fail Date of hearing re-screen pass: _____ Referred: _____

Medical History

None Yes No

Premature birth Yes No

R.S.V..... Yes No

Bronchiolitis..... Yes No

Hepatitis Yes No

Heart defects/heart disease Yes No

Seizures Yes No

Recurrent ear infections Yes No

Drug-resistant organisms (MRSA/VRE) .. Yes No

HIV / AIDS Yes No

Eczema Yes No

Dental concerns Yes No

Other health problems? Yes No _____

Hospitalizations? Yes No _____

Are immunizations on schedule? Yes No _____

Previous reaction to immunizations? ... Yes No _____

SURGICAL HISTORY

None? Yes No _____

Appendectomy? Yes No _____

Tonsillectomy? Yes No _____

Adenoidectomy? Yes No _____

Ear tube placement? Yes No _____

Other previous surgical procedures? Yes No _____

(continued, over...)

FAMILY HISTORY

Condition	Relation	Age Diagnosed
Unknown? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Aneurysms? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Bleeding tendencies? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Pulmonary embolism? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
High cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
High blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sudden infant death syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Birth defects? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Genetic condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Alcohol dependency? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
HIV/AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Thyroid disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Is child's father deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cause of death: _____	Age: _____
Is child's mother deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cause of death: _____	Age: _____

SOCIAL HISTORY

With whom does the child live? _____ Total number of siblings: _____

Sibling's name	Relationship to patient	Birth date
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

(continued...)

SOCIAL HISTORY *(continued)*

Day care provider: Home day care Day care provider Relative or friend None

Religious or cultural practices we need to know to better serve child's needs?... Yes No

HEALTH RISK PROFILE

Latex Allergy Risk:

Allergy to latex? Yes No _____

Reaction to medical procedure? Yes No _____

Exposure to secondhand smoke? No Yes (If "yes," who and where?: _____)

Pediatric Health Risk Prevention:

Bike helmet use? Yes No _____

Car seat/booster seat use? Yes No _____

Seatbelt use? Yes No _____

Smoke detectors in home? Yes No _____

Carbon monoxide detectors in home? .. Yes No _____

Pediatric Health Risk Hazards:

Lead exposure? Yes No _____

Guns in home? Yes No _____

Domestic violence?..... Yes No _____

Alcohol use in home? Yes No _____

Drug use in home? Yes No _____

Dental visit during past year? Yes No _____