

Initial History (Pediatric)

Name of Patient _____ Sex: Male Female DoB ___/___/___ Chart # _____
 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

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

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

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

Yes No

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

If in school, has the patient had...

- 1. tutoring outside of the classroom? Yes No _____
- 2. placement in a special or resource class? Yes No _____
- 3. to repeat a grade? Yes No _____
- 4. educational or psychological testing? Yes No _____
- 5. behavioral problems? Yes No _____

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

Provider Comments

History Reviewed by _____