



PEDIATRIC HISTORY FORM

CHILD'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE FORM FILLED OUT \_\_\_\_\_

A. BIRTH HISTORY

- 1. Birthplace \_\_\_\_\_
2. Birthdate \_\_\_\_\_
3. Was pregnancy normal? \_\_\_\_\_
4. Was delivery normal? \_\_\_\_\_
5. Was baby full term? \_\_\_\_\_
6. Birth weight \_\_\_\_\_
7. Birth length \_\_\_\_\_
8. Any nursery problem? \_\_\_\_\_

B. GROWTH AND DEVELOPMENT

- 1. Ages when first:
Sat \_\_\_\_\_ Crawled \_\_\_\_\_
Rolled \_\_\_\_\_ Walked \_\_\_\_\_
First Teeth \_\_\_\_\_ Toilet Trained \_\_\_\_\_
2. School History:
Year in school \_\_\_\_\_ Nursery \_\_\_\_\_
Grades averaged \_\_\_\_\_
School name \_\_\_\_\_
School problems? \_\_\_\_\_
Attends special school or classes? \_\_\_\_\_
Discipline or behavior problem? \_\_\_\_\_
Ever seen by Psychologist, Speech Therapist or Special Teachers? \_\_\_\_\_

C. PAST MEDICAL HISTORY

- 1. Any problems with:
Sleeping? \_\_\_\_\_ Bedwetting? \_\_\_\_\_
Weight/Height? \_\_\_\_\_ Nail Biting? \_\_\_\_\_
Nightmares? \_\_\_\_\_
2. Diet \_\_\_\_\_
Nursed or Bottle Fed? \_\_\_\_\_
Any Colic problems? \_\_\_\_\_
Use special diets? \_\_\_\_\_
Taking Vitamins? \_\_\_\_\_
Taking Fluoride? \_\_\_\_\_
3. Contagious Diseases (What age?)
Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_
Chickenpox \_\_\_\_\_
Scarlet Fever \_\_\_\_\_
Any other? \_\_\_\_\_
4. Immunizations (Shots) — Please give ages and/or dates.
Hepatitis B \_\_\_\_\_ Boosters \_\_\_\_\_
DTap/DTP \_\_\_\_\_ Boosters \_\_\_\_\_
H. Influenzae type b (Hib) \_\_\_\_\_ Boosters \_\_\_\_\_
Polio Series \_\_\_\_\_ Boosters \_\_\_\_\_
Measles, Mumps, Rubella \_\_\_\_\_ Boosters \_\_\_\_\_
Rotavirus \_\_\_\_\_ Boosters \_\_\_\_\_
Varicella \_\_\_\_\_ Boosters \_\_\_\_\_
TB (Tine) Test \_\_\_\_\_ Boosters \_\_\_\_\_
Others \_\_\_\_\_
5. Medications (Does Your Child Take Any Now?) \_\_\_\_\_

D. HOSPITALIZATIONS

(When, Where, Why?) \_\_\_\_\_

E. SURGERY

(When, Where, Why?) \_\_\_\_\_

F. SERIOUS INJURIES

(When, Where?) \_\_\_\_\_

G. ALLERGIC REACTIONS

(Drugs, Asthma, Hives, Eczema, Hay Fever) \_\_\_\_\_

H. FAMILY HISTORY

- 1. Father: Living? \_\_\_\_\_ Age Now \_\_\_\_\_ Health \_\_\_\_\_
2. Mother: Living? \_\_\_\_\_ Age Now \_\_\_\_\_ Health \_\_\_\_\_
3. Brothers/Sisters: \_\_\_\_\_ How Many? \_\_\_\_\_
4. Any Family History of: Diabetes \_\_\_\_\_ Allergies \_\_\_\_\_
Convulsions \_\_\_\_\_ Heart Disease \_\_\_\_\_ TB \_\_\_\_\_
Cancer \_\_\_\_\_ A.I.D.S./HIV \_\_\_\_\_ Hepatitis \_\_\_\_\_

I. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA?

WHERE DID YOU LIVE BEFORE COMING TO THIS AREA?

J. GENERAL SURVEY

Has your child had any unusual problems with the following?
Head \_\_\_\_\_
Eyes \_\_\_\_\_
Ears/Nose/Throat \_\_\_\_\_
Chest/Heart/Lungs \_\_\_\_\_
Stomach \_\_\_\_\_
Kidneys \_\_\_\_\_
Bladder \_\_\_\_\_
Bones, Muscles, Joints \_\_\_\_\_
Skin \_\_\_\_\_
Blood \_\_\_\_\_

When was your child's last blood test? \_\_\_\_\_
When was your child's last urine test? \_\_\_\_\_

K. ANY SPECIAL COMMENTS ABOUT YOUR CHILD?

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

L. YOUR LAST DOCTOR WAS \_\_\_\_\_

\_\_\_\_\_

M. REFERRED BY \_\_\_\_\_

\_\_\_\_\_