

Pediatric Patient History

Today's Date _____

Child's Name _____ Birthdate _____ Sex: male female

Mother _____ Birthdate _____ Occupation _____

Address _____ Phone _____

Father _____ Birthdate _____ Occupation _____

Address _____ Phone _____

Legal Guardian (if other than parent) _____ Phone _____

Address _____

Siblings (names and birthdates) _____

Parents are: Married _____ Single _____ Separated _____ Divorced _____
Pets (Describe) _____ Smokers in the home (who) _____
Firearms in House? Yes No Smoke Detectors in the house? Yes No
Water fluoridated? Yes No Diet _____
Does child attend daycare? Yes No Religious Preference: _____

ALLERGIES (Drugs, Food, Environment) _____

BIRTH HISTORY

Length of pregnancy _____ Type of delivery: vaginal c-section
Weight _____ Length _____
Type of feeding: breast formula (name) _____
Complications during pregnancy, labor or delivery _____
Problems in Nursery _____

DEVELOPMENT

At what age did the child first:

Roll over _____ Sit alone _____ Speak single words _____
Crawl _____ Walk alone _____ Make sentences _____
Toilet train _____

Did the child have any of the following problems during the first few months of life? (check if yes)

Jaundice _____ Anemia _____ Breathing difficulties _____
Trouble feeding _____ Seizures _____ Blue spells _____
Severe colic _____ Infections _____ Required oxygen _____

CHILDHOOD ILLNESSES

Has the child had any of the following? (check if yes)

Chicken pox _____ Meningitis _____ Tubes in ears _____ Pneumonia _____
Asthma/wheezing _____ Seizure _____ Heart murmur _____ Frequent ear infections _____
Other chronic or ongoing medical problems _____

HOSPITALIZATIONS (for surgery, accidents, or injuries). List date and reason for hospitalization

MEDICATIONS List all including vitamins, fluoride, iron, prescription, non-prescription drugs, and herbs.

FAMILY HISTORY Do any of the child's close relatives (parents, grandparents, brothers or sisters) have any of the following? (check if yes)

High blood pressure
Heart disease
Sickle cell
Cancer

Diabetes
Bleeding disorder
Cystic Fibrosis
Mental problems

Allergies
Asthma
Alcoholism

Seizures
Kidney disease
High cholesterol

IMMUNIZATIONS Please provide us with a current list of all immunizations received.

DOES THE CHILD HAVE ANY UNUSUAL PROBLEM WITH (check if yes)

Behavior
Discipline
Breath holding
Hyperactivity

Temper tantrums
Vision
Speech
Thumbsucking

Nightmares
Bedwetting
Toilet training

Trouble in school
Learning Difficulty
Attention Deficit

WHAT RECENT PROBLEMS HAS THE CHILD HAD? _____

WHAT CONCERNS DO YOU HAVE TODAY? _____
