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

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, is she having any problems?	☐	☐	

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

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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________________