kids + pediatrics

Patient History

NAME _____ DOB _____ EXAM DATE _____ SEX _____

PARENT'S FULL NAME _____

PARENT'S FULL NAME _____

PRENATAL / BIRTH HISTORY

Method of Delivery Labor Length
Gestational Age
Birth Weight
APGAR Scores
G ___ P ___ (# of pregnancies / # of living children)
Child's Blood Type
Complications
Jaundice
Phototherapy Duration
Time of Birth Place of Birth
Age of Mother Maternal Blood Type __ Rh__
Maternal Medication Use
Maternal Smoking/Drug Use
Breastfed/Bottle-fed Number of Months

PAST MEDICAL HISTORY

Allergies
Feeding Problems
Operations
Hospitalizations

BEHAVIOR / DEVELOPMENTAL HISTORY

Developmental Milestones Normal? Y N
Held Up Head
Rolled Over
Sat Alone
Stood Alone
Walking
Talking
(*If YES to the following, please explain below.*)
Behavior Problems
Learning Problems
Problems Relating to Peers
School Progress
Sleep Problems

REMARKS _____

_____

_____

_____

FAMILY / SOCIAL HISTORY

Parent's Age Education Occupation
Parent's Age Education Occupation
Marital Status Child Lives With
Adoption
Number of People Living at Home
Smokers in the House?
Alcohol / Drugs / Guns?
Pets
Siblings Ages
Grandparents Living with Family? (Mom's? Dad's? Both?)

FAMILY RELEVANT ILLNESS

Please circle all that apply -- for immediate family members, including grandparents -- and note who has/had the illness (and the specific type, if applicable.)

Alcoholism
Arthritis
Asthma
Birth Defects
Blood Disease
Bone Disorders
Cancer
Coronary Artery Disease
Drug Dependency
Ear Disorders
Glandular Disease (Diabetes, Thyroid)
High Blood Pressure
High Cholesterol
Joint Disorders
Kidney Disease
Lung Disease
Mental Retardation
Muscle Disease
Neurological Disease
Obesity
Psychiatric Disorders
Sickle Cell
Sudden Death (<55 Yrs Old)
Urinary Disease
Venereal Disease