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PEDIATRICS●ADOLESCENT MEDICINE●PEDIATRIC ALLERGY

PATIENT HISTORY FORM

(To be filled out by parent or guardian)

NAME: ________________________________ DOB: ______________ ☐ Male ☐ Female

PREGNANCY AND BIRTH

(For Newborns & Infants)

1. Did you have an illness during your pregnancy? ☐ YES ☐ NO
2. Did the baby come on time? ☐ YES ☐ NO
3. What was the birth weight? Weight: ______lbs _____oz
4. Did your baby have trouble starting to breath? ☐ YES ☐ NO
5. Did the baby have any trouble in the hospital? ☐ YES ☐ NO
6. List any medications taken during pregnancy: ____________________________________

** Please provide more information for yes answers to the above: ________________________

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FEEDING AND DIGESTION

1. Was there severe colic or any unusual feeding problems in infancy? ☐ YES ☐ NO
2. Do any foods disagree with him/her? ☐ YES ☐ NO
3. Does he/she often have diarrhea? ☐ YES ☐ NO
4. Has constipation ever been much of a problem? ☐ YES ☐ NO

FAMILY HISTORY

1. Are the child's parents both in good health? ☐ YES ☐ NO
2. List ages, sex, and general health of brothers and sisters: __________________________

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3. Have any of your children died? ☐ YES ☐ NO

Additional explanations and information: ____

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(over)

INFECTIONS, ILLNESSES, MISCELLANEOUS PROBLEMS AND DEVELOPMENT

Has your child:

1. Had as many as three attacks of ear trouble? ☐ YES ☐ NO
2. Had more than three colds or throat infections with a fever a year? ☐ YES ☐ NO
3. Had any trouble with urination? ☐ YES ☐ NO
4. Ever had a seizure? ☐ YES ☐ NO
5. Had any trouble with hearing? ☐ YES ☐ NO
6. Does your child have any trouble with vision? ☐ YES ☐ NO
7. Has there been any developmental delay of speech, walking, sitting up, etc? ☐ YES ☐ NO
8. Does your child have trouble sleeping? ☐ YES ☐ NO
9. Does your child have dental problems? ☐ YES ☐ NO
10. Please indicate the following that your child has had:

☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella (chicken pox) ☐ Pertussis (Whooping Cough)
☐ Pneumonia ☐ Tonsillectomy ☐ Adenoidectomy ☐ Serious Accident ☐ Fracture ☐ Other

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ALLERGIES

Has your child ever had:

1. Eczema or hives? ☐ YES ☐ NO
2. Wheezing or asthma ? ☐ YES ☐ NO
3. Allergies or reactions to any medications or injections? ☐ YES ☐ NO
4. Does he/she tend to have a stuffy nose or "constant" cold? ☐ YES ☐ NO

BEHAVIOR

Does your child:

1. Get along well in school? ☐ YES ☐ NO
2. Get along well with other children? ☐ YES ☐ NO
3. Have any of the following problems?

☐Nail biting ☐ Irritability ☐ Speech problems ☐ Thumb sucking ☐ Bedwetting ☐ Breath Holding
☐ Nightmares ☐ Jealousy ☐ Temper tantrums ☐ Refusal to toilet train ☐ Other:

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TESTS AND IMMUNIZATIONS

(Please give nurse immunization or other pertinent records to copy onto your chart)