PEDIATRIC PATIENT HISTORY

Today's Date _____

Child's Name _____ Birthdate _____ Sex: Male Female
Mother _____ Birthdate _____
Address _____ Phone _____
Father _____ Birthdate _____
Address _____ Phone _____
Legal guardian (if other than parent) _____ Phone _____
Address _____
Siblings (names and birthdates)
_____
_____
Parents are: married ___ single ___ separate ___ divorced ___
Members of household _____
_____
Pets in the home _____ Smokers in the home _____
Water fluoridated? yes ___ no ___ Diet _____
Does child attend daycare? _____ Comments _____

ALLERGIES (please list) _____

BIRTH HISTORY
Length of pregnancy _____ Type of delivery: vaginal _____ C-section _____
Weight _____ Length _____ Apgar scores _____ / _____
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? (circle if yes)

jaundice	anemia	breathing difficulty
trouble feeding	seizures	blue spells
severe colic	infections	required oxygen

CHILDHOOD ILLNESSES Has the child had any of the following? (circle 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

_____
_____

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

_____

_____

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

High blood pressure	Diabetes	Allergic disease	Seizures
Heart disease	Bleeding disorders	Asthma	Kidney disease
Sickle cell	Cystic fibrosis	Alcoholism	High cholesterol
Cancer	Mental problems		

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

DOES THE CHILD HAVE ANY UNUSUAL PROBLEMS WITH (circle if yes)

behavior	temper tantrums	nightmares	trouble in school
discipline	vision	bedwetting	learning difficulty
breath holding	speech	toilet training	attention deficit
hyperactivity	thumb sucking		

WHAT RECENT PROBLEMS HAS THE CHILD HAD? _____

_____

WHAT CONCERNS DO YOU HAVE TODAY?

_____

_____

_____

_____

_____

_____