Pediatric History Form

Child's Name: _____ Child's Date of Birth: _____

Today's Date: _____ MRN (*office use only*): _____

Please use designated space below to explain answers.

Where did your child receive previous medical care? _____

_____

Yes No Was the pregnancy normal? _____

Yes No Were labor and delivery normal? _____

Yes No Were there complications in the nursery? _____

Yes No Was your child delivered via cesarean section?

Yes No Was your child delivered at full term (40 weeks)? If no, how many weeks pregnant was mother at delivery? ___

What was your child's weight at birth? _____

Yes No Does your child have any chronic illnesses such as asthma, diabetes, seizures, etc._____

_____

_____

Yes No Does your child take any medications? _____

Yes No Is your child allergic to any medicines? _____

Yes No Has your child ever been hospitalized or had surgery? _____

_____

Yes No Are there any smokers in the home? _____

Yes No Are there any pets in the home? _____

Yes No Do you consider your child to be healthy? _____

Have any of your child's family members been diagnosed with the following:

Allergies	Yes	No	Whom? _____
Anemia, Asthma, Birth Defects	Yes	No	Whom? _____
Bleeding Problems	Yes	No	Whom? _____
Breathing Problems	Yes	No	Whom? _____
Cancer	Yes	No	Whom? _____
Convulsions/Seizures	Yes	No	Whom? _____
Deafness	Yes	No	Whom? _____
Depression	Yes	No	Whom? _____
Developmental Delay	Yes	No	Whom? _____
Diabetes	Yes	No	Whom? _____
Heart Disease	Yes	No	Whom? _____
Hyperactivity	Yes	No	Whom? _____
Kidney Problems	Yes	No	Whom? _____
Tuberculosis	Yes	No	Whom? _____

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**** If patient was born at 35 weeks gestation or less, send chart to synagis coordinator.**