

# 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

Is your child having any medical problems?  Yes  No

Are immunizations up to date?  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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. had a serious injury or accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. chickenpox? When? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. allergies, asthma, bronchitis, respiratory infections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. repeated ear infections, tubes, difficulty with hearing?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. problems with eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. heart problems or a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. anemia, bleeding problems or blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. abdominal pain, constipation requiring doctor visits?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. recurrent vomiting, recurrent diarrhea, blood in stools?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. bladder or kidney infections, bed-wetting after 5 yrs.?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. recurrent skin problems (acne, eczema, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. headaches, convulsions, other neurologic problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. diabetes, thyroid or other endocrine problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. If female, has she started her menstrual periods?	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, is she having any problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

\_\_\_\_\_  
 \_\_\_\_\_

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 pregnancy?    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. <input type="checkbox"/> _____ Allergies                | 12. <input type="checkbox"/> _____ Ear infections /tubes               | 23. <input type="checkbox"/> _____ Learning prob. /Attent. span     |
| 2. <input type="checkbox"/> _____ Anemia / Blood disorders | 13. <input type="checkbox"/> _____ Eczema                              | 24. <input type="checkbox"/> _____ Liver disease                    |
| 3. <input type="checkbox"/> _____ Arthritis                | 14. <input type="checkbox"/> _____ Emotional / Behavioral              | 25. <input type="checkbox"/> _____ Mental illness                   |
| 4. <input type="checkbox"/> _____ Asthma                   | 15. <input type="checkbox"/> _____ Epilepsy or convulsions             | 26. <input type="checkbox"/> _____ Mental retardation               |
| 5. <input type="checkbox"/> _____ Birth defects            | 16. <input type="checkbox"/> _____ Eye or visual problems              | 27. <input type="checkbox"/> _____ Migraine Headaches               |
| 6. <input type="checkbox"/> _____ Bladder / Kidney         | 17. <input type="checkbox"/> _____ Heart attack / stroke before 50 yrs | 28. <input type="checkbox"/> _____ Obesity                          |
| 7. <input type="checkbox"/> _____ Cancer                   | 18. <input type="checkbox"/> _____ Heart problems, other               | 29. <input type="checkbox"/> _____ Respiratory infections           |
| 8. <input type="checkbox"/> _____ Deafness                 | 19. <input type="checkbox"/> _____ Hereditary problems                 | 30. <input type="checkbox"/> _____ Stomach / GI                     |
| 9. <input type="checkbox"/> _____ Diabetes before 50 yrs   | 20. <input type="checkbox"/> _____ High blood pressure before 50 yrs   | 31. <input type="checkbox"/> _____ Thyroid or other endocrine prob. |
| 10. <input type="checkbox"/> _____ Drug / Alcohol abuse    | 21. <input type="checkbox"/> _____ High cholesterol                    | 32. <input type="checkbox"/> _____ Tuberculosis                     |
| 11. <input type="checkbox"/> _____ Drug allergies          | 22. <input type="checkbox"/> _____ Immunity problems / HIV             | 33. <input type="checkbox"/> _____ Other                            |

Provider Comments

History Reviewed by \_\_\_\_\_