Your HEALTHCARE Place

Patient Name _____ **Date of Birth:** _____

PEDIATRIC PATIENT HISTORY FORM

BIRTH HISTORY

Delivery: Vaginal Cesarean - due to:	Birth Weight:
Was this child premature? Yes No If yes, how many weeks? _____	Were there problems with this child's delivery? Yes No If yes, list:
Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? If yes, please list:	
Did this child need special treatment while in the hospital such as oxygen, transfusions, lights?	
Was (is) this child breast fed? No Yes	
Did (does) this child have any problems with breast feeding or formula feeding?	

SOCIAL HISTORY (Circle the appropriate answers)

Parents: Married Divorced Separated Single	
Siblings - please list:	
How many people live in your home? _____ Adults _____ Children	
Is your child currently enrolled in daycare or school? No Yes	
Does your child participate in regular exercise? No Yes explain:	
Does your child drink caffeine? No Yes	
Is there a swimming pool at home? No Yes	Any smokers at home? No Yes
Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No Yes
Any pets at home? No Yes If yes, please list:	
What is your water source?	Are guns kept in your home No Yes
Do all family members use Seat belts/care safety sets? No Yes	Do all family members use Helmets when biking? No Yes
Any issues we should be aware of? No Yes Please list:	

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MEDICAL HISTORY	
Hospitalizations? None Yes - list:	
Surgeries? None Yes - list:	
Drug Allergies? None Yes - list:	
Did you bring a copy of child's immunization record? No Yes If no, please provide as soon as possible.	Hepatitis B Vaccine? No Yes
Has your child had chicken pox? No Yes If yes, when?	Has your child had chicken pox vaccine? No Yes
Any Chronic Illnesses: none yes - list:	Has your child seen a sub-specialist? No Yes If yes, when?

REVIEW OF SYSTEMS		
Any lung problems?	None	Yes - list:
Any heart problems?	None	Yes - list:
Any kidney/urinary problems?	None	Yes - list:
Any bone/muscle problems?	None	Yes - list:
Any gastro-intestinal problems?	None	Yes - list:
Any brain/nervous system problems?	None	Yes - list:
Any genital problems?	None	Yes - list:
Any skin problems?	None	Yes - list:
Any eye/ear/nose/throat problems?	None	Yes - list:
Any developmental concerns or learining problems?	None	Yes - list:
Any behavioral problems or eating disorders?	None	Yes - list:
Any regular medications (over the counter or prescription)? Include does and frequency.		
Any medical issues we should be aware of? None Yes - list:		

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FAMILY MEDICAL HISTORY						
	Child's Father	**Child's Mother**	**Sibling**	**Sibling**	**Grandparent**	**Other**
Year of Birth (if known)						
Year of Death (if known)						
Cause of Death (if known)						
Heart Disease						
High Blood Pressure						
Stroke						
High Cholesterol						
Anemia						
Diabetes (note if onset as Adult or Child)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Social Problems						
Psychiatric Problems						
Cancer (type)						
Kidney Disease						
Migraines						
Seizures						
Congenital Birth Defects						
Eating Disorder						
Other:						
Other:						

COMMUNICATION NEEDS:

Language if other than English: Child _____ Parent(s)_____
Any special communication needs? No Yes
If yes, explain:_____

PATIENT EDUCATION ASSESSMENT:

Would you prefer patient education be provided to you or your child by:
Demonstration
Written Materials
Other Explain:_____

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for your child? _____Y _____N
If YES, explain:_____

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____