

PEDIATRIC PATIENT PERSONAL HISTORY

Confidential Record: Information will not be released without the permission of parent or guardian.

Patient's Name: _____

Age: _____

Pregnancy and Birth

- Mother's age when pregnant _____
- Obstetrician's name: _____
- Did mother have any illness or infection during pregnancy? **Y N**
- Did she take any medications other than vitamins and iron? **Y N**
- Did mother use recreational drugs, alcohol or tobacco? **Y N**
- Was the baby on time? **Y N**
- Were there any problems with labor or delivery? **Y N**
- Type of delivery? Cesarean Section Vaginal Delivery
- What was the birth weight? _____
- Did the baby have any problems at birth? **Y N**
If yes, please explain: _____
- How many days did the mother and child stay in the hospital?
Mother: _____ Child: _____
- Where was the infant born? Hosp. Home En route to hosp.

Past Medical History

- Where has your child gone for check-ups before today?

- Date of last medical check-up? _____
- Date of last dental check-up? _____
- Date of last eye exam? _____
- Has your child had allergic reactions to any medications? **Y N**
If yes, what medications: _____
- Has your child had allergic reactions to any foods? **Y N**
If yes, what foods: _____
- Has your child had allergic reactions to any insect bites? **Y N**
If yes, what insects: _____
- Has your child had reactions to any immunizations? **Y N**
If yes, which ones: _____
- Has your child been hospitalized at any time other than birth? **Y N**
If yes, for what: _____
- Has your child had any serious injuries? **Y N**
If yes, what kind: _____
- Are any medications taken regularly? **Y N**
- If yes, which ones: _____

Family History

- Are the child's parents both in good health? **Y N**
- Circle any diseases that this child/s parents, grandparents, brothers, sisters, aunts or uncles have or had: asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS/HIV carrier, others: _____
- _____
- Have any of the child's brothers or sisters died? **Y N**
If yes, from what: _____

Feeding and Nutrition

- Is your child's appetite usually good? **Y N**
- Is it good now? **Y N**
- Was there severe colic or any unusual feeding problems during the first three months? **Y N**
- Do any foods disagree with your child? **Y N**
- During the first year is/was your child breast fed or bottle fed?
- Is your child still on formula? **Y N**
- Does your infant/child take vitamins? **Y N**
- _____ fluoride? **Y N**
- Is your water supply fluoridated? **Y N**

Review of Systems

- Has your child had frequent ear infections? **Y N**
- Has your child had any hearing problems? **Y N**
- Has your child had any problems with teeth? **Y N**
- Any eye problems (seeing or with eyes)? **Y N**
- Is there asthma, pneumonia, or recurrent cough? **Y N**
- Does he/she have a heart murmur or any heart problems? **Y N**
- Are there any problems with urination? **Y N**
- Any problems with diarrhea or constipation? **Y N**
- Have there been any convulsions or other problems with the nervous system? **Y N**
- Any eczema, hives, or other skin conditions? **Y N**
- Has your child ever been anemic (low blood)? **Y N**
- Please list any other medical problems: _____
- Has your child experienced any of the following conditions / injuries? chicken pox eating paint broken/fracture bones

Development and Behavior

- Has the child done things at the same time as his siblings or friends? **Y N**
- At what age did your child sit alone? _____
- At what age did your child walk alone? _____
- Did your child say any words by the time he/she was 1 ½ years old? **Y N**
- Does your child have any problems sleeping? **Y N**
- What grade is your child in? _____
- Has your child ever failed a grade? **Y N**
- Has your child had any behavioral problems in school? **Y N**
- Does your child get along with other children? **Y N**
- Check if your child has had any of the following:
 - nail biting thumb sucking bed wetting
 - lie a lot hyperactivity nightmares
 - speech problems problems with discipline
 - overly nervous steal overly shy
 - easily upset jealous

Safety and Environment

- Do you live in a private house, apartment, mobile home or other: _____?
- Do you know the hottest temperature of the water in your pipes? **Y N**
- Is there a working smoke alarm on each floor of your house? **Y N**
- Does your child always use a car seat/seat belt when riding in a car? **Y N**
- Does your child use a tooth brush daily? **Y N**
- Are there any smokers in the household? **Y N**
- Are there any problems with the conditions of your home? (peeling paint, insects, rats or mice) **Y N**
- Are there any guns or weapons kept in the house? **Y N**
- Does your child wear a helmet when riding a bike? **Y N**
- Do you have pets in the home? **Y N**

Do you have a record of immunizations?

Y N

Physical History

- Who lives in the home with the child? (complete chart-next page)
- Who takes care of the child on a typical day? _____
- Does your child regularly spend time with a baby sitter or at a day care? **Y N**
- If yes, how many time per week and hours per day?

Chart #: _____

We would like to know who lives in the home with the child.

Name	Relationship	DOB	Health