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Pediatric Patient History

Name of Child: ______________________________ **SSN:** ______________
Last First Middle

Date of Birth: _____/_____/_____ **Place of Birth: Hospital:** ______________
City/State: ______________

Child's Address: ____
Street Apt. City State Zip

Home Phone Number: (___) __________ **Cell Phone Number:** (___) __________

Work Phone Number: (___) __________ **To Leave Messages:** (___) __________
What is this person's name? __________

Please complete this section for all people who live in the same home as the child.

Full Name	How Related	Age	Work	Education

Who has legal custody of the child? ____________________ **Relationship** __________

Who is the child's primary doctor? ______________________________
Name Phone

Do other doctors also see the child? If so, please list them.

Name of Doctor	Address	Phone Number	Why does child see this doctor?

What pharmacy do you usually use? ______________________ ( ) ______
Name Location Phone

Why are we seeing your child today? ______________________________

____

____

____

Please provide us with some information about your child's history.

Biological Mother's Pregnancy History:

1. **Pregnancy:** Total number of pregnancies:______ This was pregnancy number: ______
   Did mom have any miscarriages? _____________ How many? _____________

2. **Please check the box if any of the following problems occurred during the pregnancy of the child we are seeing today.**

Unusual swelling	Unusual weight gain	High blood pressure
Infection	Unusual vomiting	Bleeding
Alcohol use	Tobacco use	Drug use

Child's History:

3. **Birth:** Was this child born: early? ________ late? _________ on time? ________
   Was labor induced? _______ Why? ____
   Did mom need to have a Cesarean Section? ____
   Why? ____
   Birth weight: ___________ Apgar scores (if known): ____________________________
   Please describe any problems the baby had right after birth: ____________________________
   ____

4. **Please check the box if your baby had any of these problems during the first year of life.**

Problems sucking	Choking	Lots of spitting/vomiting
Poor eating	Seemed stiff	Seemed limp
Cried a lot	Seemed too quiet	Didn't gain enough weight

Any other problems during the first year? ____
____
____

5. **At what age did your child first do each of these things?**

Hold head up	Roll over	Sit alone
Crawl	Pull up	Walk
Feed self	Speak first word	Use sentences
Dress self	Have bladder control	Have bowel control

Did your child ever lose any developmental milestones? When? ______________________
____

6. **Behavior: Describe any behavioral concerns or problems with your child:** _____________
____
____
____

7. Please tell us about all the medicines your child takes at this time.

Name of medicine	Amount taken	How often	What for

8. Please tell us about any hospital stays or surgeries your child has had.

Date of stay/surgery	Name of hospital	Reason for hospital stay	Surgery performed

9. Does your child have any other medical problems? If so, please describe them here.

System	**Type of problem (s)**
Breathing	
Heart	
Skin	
Psychiatric/emotional	
Eyes/ears/nose/throat	
Stomach/intestines	
Kidneys/bladder	
Blood	
Immune system/infections	
Muscles/bones	
Seizures/head injury	

10. Are immunizations up to date? Yes ______ No ______

11. Does your child have any allergies? If so, to what and what kind of a reaction is there?

Allergy	Reaction

12. Please tell us about all the medicines your child has taken in the past.

Medicine name	Why taken	When started/stopped	Why stopped

13. Please check the box and write who if anyone on either mom or dad's side of the family has these problems.

Headaches	Cerebral Palsy	Mental Retardation or slow development
Weak muscles	Miscarriages or baby who died at a young age	Tics
ADHD/ADD	Psychiatric problems	Seizures

14. Please tell us about your child's school or day care.

Name and city where located.	
Grade or program child is in.	
Receiving any special services? What type?	
Results of any special testing done.	

Please attach a recent photograph of your child, if one is available.

Parent/Legal Guardian Signature: ________________________ **Date: _____________**
How are you related: _______________________________

MD/ARNP Signature: __________________________________ **Date: _____________**