NEW PEDIATRIC PATIENT HISTORY AND REVIEW

(To be filled out by the parent)

Mother's name: ________________________________ Age: ________________ Occupation: __________________________

Father's name: _________________________________ Age: ________________ Occupation: __________________________

Who referred you to our practice?____

PREGNANCY AND BIRTH HISTORY:

1. Mother's age at birth __________________________
2. Any complications/infections at birth? No Yes

   If "yes," describe ______________________________________

PAST MEDICAL/SURGICAL HISTORY:

1. Where has your child gone for health care?

   ____
2. Reason for change?____
3. Date of last checkup? _______________________________________
4. Any hospitalizations or surgeries since birth? No Yes

   If "yes," list ____
5. Any serious injuries? No Yes

   If "yes," list ____
6. Any history of frequent infections? No Yes

   If "yes," list ____
7. Any medications taken regularly? No Yes

   If "yes," list ____
8. Has your child had any allergic reactions to any

   foods, medications, or insect bites? No Yes

   If "yes," describe _______________________________________
9. List any other health problems ________________________________
10. Does your child have a record of immunizations? No Yes

FAMILY HISTORY: Please list immediate family members with a history of any of the following:

Anemia_________________________ Hepatitis_____________________

Asthma_________________________ GI problems__________________

Allergies_______________________ High cholesterol_______________

Diabetes_______________________ Skin problems_________________

Obesity________________________ Alcoholism___________________

Blood problems_________________ Arthritis______________________

Lung problems_________________ TB_________________________

High blood pressure______________ Seizures_____________________

Heart disease___________________ Migraines____________________

Mental retardation_______________ Stroke_______________________

Kidney problems________________ Cancer______________________

Thyroid problems_______________ Other________________________

3. Who lives at home? ____
4. Does anyone at home smoke or is the child

   exposed to smoke? No Yes
5. Type of home: house/apt/mobile home/other
6. Water supply: city water/well water
7. Any pets? No Yes

   If "yes," indoor/outdoor? Type of pet(s)

   ____
8. Describe childcare outside of the home: ________________________
9. Name of child's school and grade: ____________________________
10. Child's hobbies: ____

FEEDING AND NUTRITION:

1. Does child take vitamins? No Yes

   If "yes," list ___________________________
2. Is your child's appetite usually good? No Yes

DEVELOPMENT/BEHAVIOR:

1. How does your child compare to others of his/her own age?

   Below average/average/above average
2. Does he/she get along with other children? No Yes
3. Does he/she get in trouble at school? No Yes
4. Circle if your child has any of the following:

   speech problems nail biting

   discipline problems bad temper

   thumb sucking > 4 years bed wetting

   toilet training problems hyperactivity

SAFETY/ENVIRONMENT:

1. Is your hot water heater set at 120 degrees? No Yes
2. Are there home smoke alarms on each floor? No Yes
3. Is there a fire extinguisher in the house? No Yes
4. Are there any fire arms in the house? No Yes

   If "yes," are they unloaded/locked storage? No Yes
5. Does your child always wear a safety restraint in the car? No Yes
6. Does your child always wear a helmet when

   riding a bike or skating? No Yes

SOCIAL HISTORY:

1. Parental marital status: please circle

   Married/Separated/Divorced/Widowed/Single parent
2. Sibling name(s) and age(s): ________________________________

Patient Name: ____

Date of Birth: ____

Date of Exam: ____