PEDIATRIC HISTORY FORM

Date _____

MRN _____

Patient Name _____ ☐ Male ☐ Female Birth Date _____

Today's Date _____

Parent's Name _____ Age _____ Occupation _____

Parent's Name _____ Age _____ Occupation _____

Mark appropriate box for parents:

Married ☐ Single ☐ Separated ☐

Divorced ☐ Widowed ☐

Child lives with: _____

Number of people in Household: _____

How many children has the mother had: _____

Which number is this one: _____

BIRTH HISTORY

During the mother's pregnancy with this child, did she:

(Circle yes or no)

1. Have high blood pressure? Yes No
2. Have sugar in your urine? Yes No
3. Have a Kidney or bladder infection? Yes No
4. Take medicines prescribed by her doctor or over the counter? Yes No
   If yes, what? _____
5. Consume Alcohol? If yes, amount _____
6. Use any tobacco products? If yes, amount _____ Yes No
7. Have a dependency on drugs? Yes No
8. Was this child premature: Yes No
   If yes, number of weeks at birth _____
9. Did you have a difficult delivery? Yes No
10. Was the birth:
    Normal Vaginal ☐ Breech ☐ Cesarean ☐
11. Child's weight at birth _____
12. Was there a jaundice problem**?** Yes No
13. Did the child have any of the following while in the nursery:
    - Breathing difficulty Yes No
    - Low blood sugar Yes No
    - Seizures Yes No
    - NICU Stay Yes No
14. Did the mother have any maternal history of the following?
    - HSV Yes No
    - Hep C Yes No
    - Hep B Yes No

DIET HISTORY

Has this child been:

Breast fed ☐ Bottle fed ☐

Would you describe your child's eating habits as

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

Has your child taken Vitamins: Yes No

FAMILY HISTORY

Does the Mother or Father have any chronic illnesses? Yes No

If Yes, what? _____

Do any of your other children have any chronic illness? Yes No

If yes, what? _____

Have any of your child's family (include siblings, parents, grandparents, uncle or aunts) had any of the following illnesses or disorders:

(Mark an X in appropriate box)

Allergies		Diabetes	
Birth Defects		Hypertension	
Anemia		Heart Disease	
Arthritis		Kidney Disease	
Cancer		Intellectual Disability	
Breast		Muscular Dystrophy	
Lung		Cerebral Palsy	
Colon		Psychiatric Problem	
Asthma		Rheumatic Fever	
Chronic Bronchitis		Tuberculosis	
ADHD		Unexpected death of a child	
Ear / Eye Disease		Autism	

Does your child have any known allergies to medicines, food or pollen? Yes No

If yes, what _____

PAST MEDICAL HISTORY

Surgeries _____

Hospitalizations _____

List any medicines which your child takes:

Past Chronic Diagnoses: (ADHA, Asthma)