

PEDIATRIC HISTORY FORM

NAME: _____ AGE: _____ TODAY'S DATE: _____

A. BIRTH HISTORY

1. Birthplace: _____
2. Birthdate: _____
3. Was pregnancy normal? Yes No
4. Was delivery normal? Yes No
5. Was baby full term? Yes No
6. Birth weight: _____ Length: _____
7. Any nursery problem? Yes No

B. GROWTH AND DEVELOPMENT

1. Ages when first:
Sat _____ Crawled _____
Rolled _____ Walked _____
First Tooth _____ Toilet trained _____
2. School History:
Year in school _____ Nursery _____
Grades averaged _____
School Name _____
School Problems _____
Attends special school/classes Yes No
Discipline or behavior problem Yes No
Ever seen by Psychologist, Speech Therapist
or special teachers? Yes No
Explain: _____

C. PAST MEDICAL HISTORY

1. Any problems with:
 Sleeping Bedwetting Nail Biting
 Weight/Height Nightmares
2. Diet:
 Nursed Bottle Fed
Any Colic Problems? Yes No
Use Special Diets? Yes No
Taking Vitamins? Yes No
Taking Fluoride? Yes No
3. Contagious Diseases (What Age?):
Measles _____ Mumps _____ Rubella _____
Chickenpox _____ Scarlet Fever _____
Any Other? _____
4. Immunizations (Shots) – Please give ages or dates
Hep B _____ Boosters _____
DTaP/DPT _____ Boosters _____
HIB _____ Boosters _____
Polio _____ Boosters _____
MMR _____ Boosters _____
Rotavirus _____ Boosters _____
Varicella _____ Boosters _____
TB _____ Boosters _____
Other: _____
5. Medications (Taking Now) _____

D. HOSPITALIZATIONS

When, Where & Why? _____

E. SURGERY

When, Where & Why? _____

F. SERIOUS INJURIES

When, Where? _____

G. ALLERGIC REACTIONS

- Drugs Asthma Hay Fever Food
 Hives Exzema

H. FAMILY HISTORY

1. Father: Living? _____ Age _____ Health _____
2. Mother: Living? _____ Age _____ Health _____
3. Brothers/Sisters _____ How Many? _____
Ages _____ Health _____
4. Family History of: Diabetes Allergies
 Convulsions Heart Disease TB
 Cancer AIDS/Hiv Hepatitis
5. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA? _____
6. WHERE DID YOU LIVE BEFORE COMING TO THIS AREA? _____

I. GENERAL SURVEY

Has your child had any unusual problems with his/her:
Head: _____
Eyes: _____
Ears/Nose/Throat _____
Chest/Heart/Lungs _____
Stomach _____
Kidneys _____
Bladder _____
Bones/Muscles/Joints _____
Skin _____
Blood _____
When was your child's last blood test? _____
When was your child's last urine test? _____

J. ANY SPECIAL COMMENTS: _____

K. YOUR LAST DOCTOR WAS: _____