PEDIATRIC HISTORY

DATE OF BIRTH: ____________________

NAME: ____________________
ADDRESS: ____________________
CITY: ____________ STATE ________ ZIP ________
FATHER'S NAME: ____________________
MOTHER'S NAME: ____________________

EMPLOYER: (mother) ____________________
POSITION: ____________ PHONE: ________
EMPLOYER: (father) ____________________
POSITION: ____________ PHONE: ________
HOME # ____________ ALT# ____________

PREGNANCY COMPLICATIONS:

	YES	NO
Pregnancy less than 9 mos.	____	____
High blood pressure	____	____
Toxemia	____	____
Medications: (if yes, list)	____	____
Bleeding (if yes, what month)	____	____
Serious illnesses or	____	____
Infections	____	____
Previous miscarriages	____	____
C-section: (if yes, why?)	____	____

BIRTH HISTORY:

Place of birth: ____________________
Birth weight: ____________ Length: ________
Length of labor: ____________________
Adopted: **No** ____ **Yes** ____

PROBLEMS:	YES	NO
Jaundice	____	____
Breathing problems	____	____
Antibiotics	____	____

Other problems (explain): ____________________

BREAST: ____________ FORMULA: ____________

DEVELOPMENT: **AT WHAT AGE DID YOUR CHILD:**

SMILE: ________ ROLL OVER: ________ SIT ALONE: ________ FIRST TOOTH: ________
WALK ALONE: ________ 1ST WORD WITH MEANING: ________ USE 3 WORD SENTENCE: ________
BLADDER TRAINED: ________ BOWEL TRAINED: ________ RIDE TRICYCLE: ________ TIE SHOES: ________

LIST MEDICATION CHILD TAKES ROUTINELY:

HOSPITALIZATIONS & OPERATIONS: DATE

1) ____________________ ____
2) ____________________ ____
3) ____________________ ____
4) ____________________ ____

CHILD'S ILLNESS:

	YES	NO	DATE
Whooping cough			
Measles			
Rubella			
Mumps			
Chickenpox			
Scarlet fever			
Meningitis			
Pneumonia			
Diabetes			
Rheumatic fever			
Convulsions			
Bed wetting			
Kidney disease			
Sickle Cell			
Allergies			
Asthma			

SERIOUS ILLNESS? DATE

School problems? **Yes** ____ **No** ____

ALLERGIES TO MEDICATIONS:

LABEL

03-03-031 2/96

Reviewed By:

THIS FORM HAS TWO SIDES
PLEASE COMPLETE
BOTH SIDES

CHILD'S FAMILY:		**Age**	**Present Health or Cause of Death**
Mother		____	____________________
Father		____	____________________
Brothers	1)	____	____________________
	2)	____	____________________
	3)	____	____________________
	4)	____	____________________
Sisters	1)	____	____________________
	2)	____	____________________
	3)	____	____________________
	4)	____	____________________

SOCIAL:	**YES**	**NO**
Smokers in household?	____	____
Pets: (List)	____	____

____
____
____
____

FAMILY HISTORY:	**Mother's Side**	**Father's Side**
Diabetes	____	____
Heart trouble	____	____
Heart attack	____	____
High blood pressure	____	____
Stroke	____	____
Cancer	____	____
Tuberculosis	____	____
Ulcer	____	____
Arthritis	____	____
Obesity	____	____
Suicide	____	____
Mental Illness	____	____
Thyroid trouble	____	____
Sickle Cell	____	____
Convulsions	____	____
Bed wetting	____	____
Allergies	____	____
Hay fever	____	____
Sinus	____	____
Asthma	____	____

Is there anything else the doctor should know to better take care of your child?

____
____
____
____
____
____