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PEDIATRIC HISTORY

Name _____ Date _____ DOB _____

BIRTH HISTORY

Birth Weight _____ Birth length _____ _____

Due date (or delivered time or # weeks early or late) _____

Problems during pregnancy or delivery _____

Problems after delivery for infant _____

Feeding: (check one or both) ☐ Breast or ☐ formula How long each? _____

Any feeding problems or food allergies? Describe _____

DEVELOPMENT AND SOCIAL HISTORY

Please give ages for the following milestone:

Sat up	_____	First tooth	_____	Toilet trained	_____
Walked	_____	First words	_____	Short sentences	_____

Any problems with speech? _____

Any problems with behavior? _____

School or preschool problems? _____

List family members and ages (mom, dad, brothers, sisters) _____

_____

Who lives with the child (list names of all household members) _____

_____

GENERAL HISTORY

Prior physician or clinic _____

Medicine allergies (describe reaction) _____

Hospitalizations (when and for what) _____

Surgeries (when and what type) _____

Describe major accidents, head injuries, poisonings, stitches, broken bones _____

_____

Current medications (include vitamins, fluoride, over the counter drugs) _____

_____

Last dental checkup _____ Problems? _____

Last physical exam _____ Age at last shot _____ Up to date? _____

Check any that your child has had:

☐ Asthma	☐ Heart murmur	☐ Anemia
☐ Urinary tract infection (bladder)	☐ Chicken pox	☐ Pneumonia
☐ Ear infections (how many _____)	☐ Seizures	☐ Stomach aches
☐ Hepatitis or jaundice	☐ Acne	☐ Headaches
☐ Eczema/skin problems	☐ Hearing problems	☐ Leg or foot problems
☐ Eye problems/glasses	☐ Undescended testicles	
☐ Bedwetting after age 7	Other _____	

FAMILY HISTORY

Check any that a relative has had:

☐ Asthma	☐ Alcoholism/drug abuse	☐ High blood pressure
☐ Bleeding problems	☐ Heart attack	☐ Sickle cell anemia
☐ Seizures	☐ Diabetes	☐ Cancer

Are there smokers in your household? Who? _____