Patience PEDIATRICS

Health History

Child's Name:_____Date of Birth:_____Age:_____
Your Name:_____Relationship to Child:_____

Child's Past Medical History

Pregnancy/ Neonatal

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild
Where was your child born?_____
Any pregnancy complications?_____
Delivered by: ☐ vaginal ☐ c-section
Reason for c-section:_____
Complications:_____
Was your child born premature? ☐ No ☐ Yes, ___weeks
Complications:_____
Apgar Scores _____1 Minute _____5 Minutes
Birth Weight_____ Length_____
Other problems in newborn period:_____

Infancy/Childhood/ Adolescence

Has your child ever been treated for or diagnosed with:

- ☐ Asthma or reactive airway disease
- ☐ Wheezing or bronchitis
- ☐ Seasonal allergies or eczema
- ☐ Food allergy
- ☐ Recurrent ear infections
- ☐ Urinary tract infections
- ☐ Pneumonia
- ☐ Genetic syndrome
- ☐ Seizures
- ☐ Anemia
- ☐ Broken bone
- ☐ Mental retardation or learning disability
- ☐ Depression/anxiety

Explain:_____

Other chronic medical conditions:_____

Has your child ever been hospitalized ☐ No ☐ Yes
Explain:_____
Previous surgeries and dates:_____

Please list any specialists that your child is currently seeing
ALLERGIES to medicine/ vaccines (list and describe kind of reaction):_____

Current medications and dose:_____

Vitamins:_____
Herbal supplements:_____
Over the counter medicines:_____

Development/ Nutrition

At what age did your child:
Walk Alone_____Sit Alone_____
Toilet Train_____Say Words_____
1st period (female)_____
Was your child breastfed ☐ No ☐ Yes, how long?___
Has your child had any unusual feed/dietary problems?
Explain:_____
Current milk intake: Type_____Amount _____oz/day

Social History

Who lives in the household with the child?
☐ Mom ☐ Dad ☐ Siblings (#____) ☐ Grandparents
☐ Other:_____
Children's parents are ☐ married ☐ unmarried ☐ divorced
Childcare: ☐ parents ☐ relatives ☐ daycare ☐ nanny
Days per week in childcare:_____
Do any household members smoke? ☐ No ☐ Yes
How many hours per day does your child spend:
Watching TV____Computer____Video Games_____
School Name:_____Grade _____
Any concerns about school performance? ☐ No
☐ Yes, explain:_____
Any concerns about peer/teacher relationships? ☐ No
☐ Yes, explain:_____
Sports/Exercise: Type:
How often:_____How long:_____

Family History

Do any family member have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart Attack/ Disease	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
ADD/ ADHD	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/ Anxiety	☐	☐	☐	☐

Please explain all positives: _____