NORTH RALEIGH FAMILY MEDICINE
8331 Bandford Way, #101 ◆ Raleigh, NC 27615 ◆ (919) 841-4566

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 ☐ Eczema

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: _____