Initial History
Pediatric

Patient's Name________________________ Sex: ☐ Male ☐ Female DoB ____ /____ /____ Chart #__________

Form completed by ________________________ Relation to patient____________________ Date ___ /___ /___

Family

Are mother and father ☐ married ☐ separated / divorced?

If separated / divorced, what is the patient's custody status?______________

If one or both parents are not living in the home, how often does child see that parent(s)?______________

Are there siblings living away from home? ☐ Yes ☐ No

If yes, give name, age and where they live:______________

List all family members living in the patient's home

Name	Relation	Birth Date	Health Problems
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

Current Medical History

Are immunizations up to date? ☐ Yes ☐ No

Is your child having any medical problems? ☐ Yes ☐ No

Do you consider your child to be in good health? ☐ Yes ☐ No

Current Medications:

Drug Allergies? ☐ Yes ☐ No

Review of Systems and Past Medical History

Does the patient now have or has ever had any of the following:	Yes	No	*Explain*
1. a serious medical problem?	☐	☐	
2. been hospitalized or had surgery?	☐	☐	
3. had a serious injury or accident?	☐	☐	
4. chickenpox? When?__________	☐	☐	
5. allergies, asthma, bronchitis, respiratory infections?	☐	☐	
6. repeated ear infections, tubes, difficulty with hearing?	☐	☐	
7. problems with eyes or vision?	☐	☐	
8. heart problems or a heart murmur?	☐	☐	
9. anemia, bleeding problems or blood transfusion?	☐	☐	
10. abdominal pain, constipation requiring doctor visits?	☐	☐	
11. recurrent vomiting, recurrent diarrhea, blood in stools?	☐	☐	
12. bladder or kidney infections, bed-wetting after 5 yrs.?	☐	☐	
13. recurrent skin problems (acne, eczema, etc)?	☐	☐	
14. headaches, convulsions, other neurologic problems?	☐	☐	
15. diabetes, thyroid or other endocrine problems?	☐	☐	
16 . If patient is female, has she started her menstrual periods?	☐	☐	
If yes, is she having any problems?	☐	☐	

History Update *(date / initial) Changes in history noted in chart on day of visit.*

Name of Patient______________________________ Date ___ /___ /___ Chart #__________

Development

Are you concerned about the patient's... Yes No

1. physical development? ☐ ☐ ______
2. mental or emotional development? ☐ ☐ ______
3. learning ability? ☐ ☐ ______
4. attention span or activity level? ☐ ☐ ______

If in school, has the patient had...

1. tutoring outside of the classroom? ☐ ☐ ______
2. placement in a special or resource class? ☐ ☐ ______
3. to repeat a grade? ☐ ☐ ______
4. educational or psychological testing? ☐ ☐ ______
5. behavioral problems? ☐ ☐ ______

Maternal and Newborn History

Pregnancy *Check if the mother had any of the following problems:*

☐ excessive wt. gain ☐ urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ venereal disease ☐ other ☐ none

______

______

Did the mother smoke, use recreational drugs or alcohol? ☐ Yes ☐ No ______

Birth

Birth Weight ______ Length ______ Apgar ______ Was baby born at: ☐ Term ☐ Early ☐ Late ______

If early, how many weeks gestation? ______ Was labor difficult or prolonged? ☐ Yes ☐ No ______

Was delivery difficult or complicated? ☐ Yes ☐ No ______

______

______

Newborn *Check if the patient had any of the following problems:*

☐ feeding problems: ☐ Breast ______ ☐ Formula ______

☐ slow weight gain ☐ multiple formula changes ☐ colic ☐ jaundice ☐ recurring vomiting ☐ recurring diarrhea

☐ blood in stools ☐ other ☐ none ______

______

Family History

If a family member has or has had any of the following problems, check the appropriate box and list the family member:

M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

1. ☐ ______ Deafness
2. ☐ ______ Allergies
3. ☐ ______ Drug allergies
4. ☐ ______ Asthma
5. ☐ ______ Eczema
6. ☐ ______ Respiratory infections
7. ☐ ______ Eye or visual problems
8. ☐ ______ Ear infections /tubes
9. ☐ ______ Tuberculosis
10. ☐ ______ Liver disease
11. ☐ ______ Immunity problems / HIV
12. ☐ ______ High cholesterol
13. ☐ ______ High blood pressure before 50 yrs
14. ☐ ______ Heart attack / stroke before 50 yrs
15. ☐ ______ Other heart problems
16. ☐ ______ Anemia / Blood disorders
17. ☐ ______ Diabetes before 50 yrs
18. ☐ ______ Thyroid or other endocrine prob.
19. ☐ ______ Obesity
20. ☐ ______ Bladder / Kidney
21. ☐ ______ Stomach / GI
22. ☐ ______ Cancer
23. ☐ ______ Epilepsy or convulsions
24. ☐ ______ Hereditary problems
25. ☐ ______ Learning prob. /Attent. span
26. ☐ ______ Emotional / Behavioral
27. ☐ ______ Mental illness
28. ☐ ______ Mental retardation
29. ☐ ______ Drug / Alcohol abuse
30. ☐ ______ Other

Provider Comments

History Reviewed by______________________