



# PEDIATRIC MEDICAL HISTORY

version 11-17-2007

Patient Name: \_\_\_\_\_ Gender: M F Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Mother: \_\_\_\_\_ Father: \_\_\_\_\_

How did you hear of South Bay Total Health? \_\_\_\_\_

## **GENERAL**

Is the child yours by: \_\_\_ Birth \_\_\_ Adoption \_\_\_ Stepchild \_\_\_ Other: \_\_\_\_\_

Present Health Concerns: Why are you bringing your child in to see the doctor? For each item, try to include the following information: a description of symptoms, when did it start, and to the best of your memory what other things were going on in your life around the time it started. If necessary, use additional sheets of paper.

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

## **PRENATAL HISTORY**

Age of Mother at birth: \_\_\_\_\_ Number of Previous Pregnancies: \_\_\_\_\_

Indicate any medical problems during this child's pregnancy \_\_\_ none \_\_\_ Specify: \_\_\_\_\_

\_\_\_\_\_

Medications during pregnancy: \_\_\_\_\_

Y / N Alcohol or Tobacco Use during pregnancy or Lactation

Mother's Allergies: \_\_\_\_\_

## **BIRTH HISTORY**

Duration of Pregnancy: \_\_\_\_\_ weeks

Delivery by: \_\_\_ vaginal birth \_\_\_ Caesarian: if so, why was C-Section performed? \_\_\_\_\_

Was Labor: \_\_\_ spontaneous \_\_\_ induced Hours of labor \_\_\_ Birth position: \_\_\_ Head first \_\_\_ Feet first

Birth Weight \_\_\_\_\_ Birth length \_\_\_\_\_ Any difficulties with birth? \_\_\_\_\_

Any medical problems during first year? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Continued on next)

**NEWBORN HISTORY**

Y / N Baby cried or breathed spontaneously within 1 or 2 minutes?  
 Y / N Was baby jaundiced?  
 Y / N Did baby spend time in hospital following birth? If yes, how long? \_\_\_\_\_

**NUTRITION AND FEEDING**

Y / N Was Child Breast Fed? If yes, how long? \_\_\_\_\_  
 How old when solid food Introduced? \_\_\_\_\_

**VACCINATION HISTORY** List the dates of all vaccinations.

MMR: \_\_\_\_\_ Polio \_\_\_\_\_ Hepatitis A \_\_\_\_\_  
 DPT: \_\_\_\_\_ Hib \_\_\_\_\_ Hepatitis B \_\_\_\_\_  
 Tetanus booster \_\_\_\_\_ Varicella \_\_\_\_\_ Other \_\_\_\_\_

**DEVELOPMENTAL HISTORY** Give the age at which your child accomplished the following skills:

Roll from stomach to back _____	Drink from a cup _____
Laugh out loud _____	Pull themselves up, stand w/support _____
Reach out for objects _____	Stand w/o support _____
Sit without support _____	Walk well _____
Feed him/herself _____	Toilet trained in daytime _____
Say Mama, Dada appropriately _____	Combine two words appropriately _____

**ALLERGIES** Indicate any allergies you suspect or are aware of:

<b>Allergen</b>	<b>Reaction</b>	<b>Allergen</b>	<b>Reaction</b>
___ Milk/dairy _____	_____	___ Medications (list)	_____
___ Wheat _____	_____	_____	_____
___ Soy _____	_____	_____	_____
___ Orange juice _____	_____	_____	_____
___ Peanuts _____	_____	_____	_____
___ Pollen _____	_____	___ Other Items	_____
___ Animals/Hair _____	_____	_____	_____
___ Dust _____	_____	_____	_____
___ Bee stings _____	_____	_____	_____
___ insect bites _____	_____	_____	_____

**FAMILY MEDICAL HISTORY**

	Father	Mother	Brothers			Sisters			Other Relatives		
			1	2	3	1	2	3			
Age (if living)											
Cancer											
Diabetes											
Heart trouble											
High Blood Pressure											
Stroke											
Epilepsy											
Mental Disorders											
Asthma											
Allergies											
Other Conditions											
Age at death											
Cause of Death											

**CHILDHOOD ILLNESSES** Please check all the following illnesses/conditions your child has had:

**Constitutional**

- Fevers/Chills/Excess Sweat
- Unexplained Weight loss/gain

**Eyes**

- Vision Problems
- Eye Pain
- Squinting/Cross-eyed

**Ears/Nose Throat**

- Hearing problems
- Ear Infections
- Tonsillitis
- Frequent Runny Nose
- Bad Breath
- Sore Throats

**Respiratory**

- Coughing/Wheezing
- Frequent Bronchitis
- Asthma
- Pneumonia
- Tuberculosis

**Skin**

- Rashes
- Unusual Moles
- Birth marks

**Cardiovascular**

- Tires easily with exertion
- Shortness of breath
- Fainting
- Heart murmur

**Gastrointestinal**

- Nausea/Vomiting/Diarrhea
- Constipation
- Blood in bowel movement
- Frequent Stomach Aches

**Genito-urinary**

- Bedwetting
- Pain with urination
- discharge from penis or vagina
- Urinary Tract Infections
- Frequent Urination

**Neurological**

- Knocked unconscious
- Weakness
- Clumsiness
- Headaches
- Seizures
- Numbness of hand/arms, feet/legs
- dizziness

**Infectious Diseases**

- Mumps
- Measles
- German Measles (Rubella)
- Chicken Pox
- Whooping Cough
- Meningitis

**Musculoskeletal**

- Broken Bones (list) \_\_\_\_\_
- Balance/Coordination Problems
- Muscle Pain
- Joint Pain
- Leg Pain

**Blood/Lymph**

- Unexplained Lumps
- Easy Bruising/Bleeding

**Emotional**

- Speech Problems (poor pronunciation, etc.)
- lack of speech/interaction
- Problems w/ sleep, nightmares
- Depression
- Nail biting/thumbsucking
- Bad temper tantrums
- Anxiety/Stress

**Current Metabolic Status:** Please indicate your child's present state for each of the following items

**Sleep.** usual bedtime, hours slept, problems with falling asleep or waking up after your fall asleep. dreams and or nightmares,

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Urination.** approximate number of times per day, waking up at night to urinate, bed wetting, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Meals** Times each day. Typical food for each meal.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Perspiration.** do you perspire excessively during the day or at night. do you NOT perspire when it would be appropriate to do so (for example, during exercise)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Energy Level** when waking up, throughout the day.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Bowel Movements.** frequency (number per day), quality of stools (small and hard, loose, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where was your child raised during the following time periods? During each of these time frames, did he or she have any major illnesses, recurring illnesses even if minor, or major injuries? (fill out only those portions that are appropriate for his/her age)

- 5 years to puberty

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- birth to 2 years

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- puberty through roughly age 20

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 2 years to 5 years

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS, VITAMINS, SUPPLEMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER INFORMATION**

Please use this space to tell us anything else about your child's health or behavior that you feel is important and that we haven't asked.

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