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# Initial History (Pediatric)

Name of Patient _____ 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**

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

Are immunizations up to date? ☐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 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. (girls) has she started her menstrual periods? | ☐ | ☐ | _____ |
| If yes, is she having 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 | *Explain* |
|---|---|---|---|
| 1. a serious medical problem? | ☐ | ☐ | |
| 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 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 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 | 11. ☐ _____ Immunity problems/HIV | 21. ☐ _____ Stomach/GI |
| 2. ☐ _____ Allergies | 12. ☐ _____ High cholesterol | 22. ☐ _____ Cancer |
| 3. ☐ _____ Drug allergies | 13. ☐ _____ High blood pressure before 50 yrs | 23. ☐ _____ Epilepsy or convulsions |
| 4. ☐ _____ Asthma | 14. ☐ _____ Heart attack/stroke before 50 yrs | 24. ☐ _____ Hereditary problems |
| 5. ☐ _____ Eczema | 15. ☐ _____ Other heart problems | 25. ☐ _____ Learning prob./Atten. Span |
| 6. ☐ _____ Respiratory infections | 16. ☐ _____ Anemia/Blood disorders | 26. ☐ _____ Emotional/Behavioral |
| 7. ☐ _____ Eye or visual problems | 17. ☐ _____ Diabetes before 50 yrs | 27. ☐ _____ Mental illness |
| 8. ☐ _____ Ear infections / tubes | 18. ☐ _____ Thyroid or other endocrine prob. | 28. ☐ _____ Mental retardation |
| 9. ☐ _____ Tuberculosis | 19. ☐ _____ Obesity | 29. ☐ _____ Drug/Alcohol abuse |
| 10. ☐ _____ Liver disease | 20. ☐ _____ Bladder/Kidney | 30. ☐ _____ Other |

**Provider Comments**

History Reviewed by _____