PEDIATRIC HISTORY FORM

CHILD'S NAME _____ AGE _____ DATE FORM FILLED OUT _____

A. BIRTH HISTORY

1. Birthplace _____
2. Birthdate _____
3. Was pregnancy normal? _____
4. Was delivery normal? _____
5. Was baby full term? _____
6. Birth weight _____
7. Birth length _____
8. Any nursery problems? _____

B. GROWTH AND DEVELOPMENT

1. Ages when first:
   Sat _____ Crawled _____
   Rolled _____ Walked _____
   First Teeth _____ Toilet Trained _____
2. School History:
   Year in school _____ Nursery _____
   Grades averaged _____
   School name _____
   School problems? _____
   Attends special school or classes? _____
   _____
   Discipline or behavior problem? _____
   _____
   Ever seen by Psychologist, Speech Therapist, or Special Teachers? _____
   _____

C. PAST MEDICAL HISTORY

1. Any problems with:
   Sleeping? _____ Bedwetting? _____
   Weight/Height? _____ Nail Biting? _____
   Nightmares? _____
2. Diet _____
   Nursed or Bottle Fed? _____
   Any Colic problems? _____
   Use special diets? _____
   Taking Vitamins? _____
   Taking Fluoride? _____
3. Contagious Diseases (What age?) _____
   Measles _____
   Mumps _____
   Rubella (German Measles) _____
   Chickenpox _____
   Scarlet Fever _____
   Any other? _____
4. Immunizations (Shots) – Please give ages and/or dates.
   DPT series _____ Boosters _____
   Polio series _____ Boosters _____
   Smallpox _____ Boosters _____
   Measles _____
   Rubella (German Measles) _____
   Mumps _____
   TB (Tine) Test _____
   Others _____
   _____
5. Medications (Does Your Child Take Any Now?) _____

D. HOSPITALIZATIONS

(When, Where, Why?) _____
_____
_____

E. SURGERY

(When, Where, Why?) _____
_____
_____

F. SERIOUS INJURIES

(When, Where?) _____
_____
_____

G. ALLERGIC REACTIONS

(Drugs, Asthma, Hives, Exzema, Hay Fever) _____
_____
_____

I. FAMILY HISTORY

1. Father: Living? _____ Age now _____ Health _____
2. Mother: Living? _____ Age now _____ Health _____
3. Brothers/Sisters _____ How Many? _____
   Ages _____ Healthy _____
4. Any Family History of:
   Diabetes _____ Allergies _____ Convulsions _____
   Heart Disease _____ TB _____ Cancer _____
   Other? _____

J. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA?

_____

WHERE DID YOU LIVE BEFORE COMING TO THIS AREA?

_____
_____

K. GENERAL SURVEY

Has your child had any unusual problems with the following?:

Head _____
Eyes _____
Ears/Nose/Throat _____
Chest/Heart/Lungs _____
Stomach _____
Kidneys _____
Bladder _____
Bones, Muscles, Joints _____
Skin _____
Blood _____
2. When was your child's last blood test? _____
3. When was your child's last urine test? _____

L. ANY SPECIAL COMMENTS ABOUT YOUR CHILD?

_____
_____

M. YOUR LAST DOCTOR WAS _____