PEDIATRIC INITIAL VISIT HISTORY

PATIENT NAME:__________________________________**DOB:**____________**DATE:**____________

Mother's Name:____Age:______________

Occupation:____

Father's Name:____Age:______________

Occupation:____

Religious preference:____

A. PREGNANCY & BIRTH

(***to be filled out by mother)***

Mother's age at birth______________________

no [ ] yes [ ] Did you have an illness during your pregnancy?

no [ ] yes [ ] Did you take any medications other than vitamins & iron?

no [ ] yes [ ] Did the baby come on time?

__________ What was the birth weight?

no [ ] yes [ ] Did your baby have any trouble starting breathing?

no [ ] yes [ ] Did the baby have any trouble while in the hospital? (jaundice, infections, etc) If yes, what kind?________________

B. PAST MEDICAL HISTORY

___________ Where has this child gone for check-ups until now?

___________ Date of last check-up?

___________ Date of last dental check-up?

no [ ] yes [ ] Allergic reactions to any medications, foods, insect bites?

Which ones?____________________________

no [ ] yes [ ] Reactions to any immunizations?

Which ones?____________________________

no [ ] yes [ ] Any hospitalizations since birth?

For what?_________________Age?_________

no [ ] yes [ ] Any serious injuries?

What kind?____________________________

no [ ] yes [ ] Are any medications taken regularly?

Which ones?____________________________

Immunization	Date	Date	Date	Date	Date
Hep B					
OPV/IPV					
DTaP					
DT					
MMR					
HIB					
TB Skin Test					
Flu Vaccine					
Tetraimmune					
Other					

C. FEEDING & DIGESTION

no [ ] yes [ ] Was there severe colic or any unusual feeding problems in the first three months?

no [ ] yes [ ] Is your child's appetite usually good?

no [ ] yes [ ] Is it good now?

no [ ] yes [ ] Do any foods disagree with him/her?

no [ ] yes [ ] Does he/she often have diarrhea?

no [ ] yes [ ] Is he/she constipated?

no [ ] yes [ ] Did he/she breast feed? If yes, how long?____________________

no [ ] yes [ ] Does he/she take vitamins, iron or fluoride?

No [ ] yes [ ] If now on formula, which one do you use?__________________

D. FAMILY HISTORY

Circle any disease that this child's parents, grandparents, brothers, sisters, aunts or uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, venereal disease, drug problems, alcohol problems inherited illness, disease, cancer, AIDS, thyroid problems, blindness, deafness, tobacco use or other.

List name, age, sex & general health of brothers & sisters:________________________________
____

no [ ] yes [ ] Are this child's parents both in good health?

E. REVIEW OF SYSTEMS

no [ ] yes [ ] Has the child had frequent ear infections?
no [ ] yes [ ] Any eye problems?
no [ ] yes [ ] Any problems with his/her teeth?
n o[ ] yes [ ] Frequent colds/sore throat?
no [ ] yes [ ] Asthma, recurrent cough or frequent lung infections?
no [ ] yes [ ] Heart murmur or any heart problems?
no [ ] yes [ ] Problems with urination, the kidneys or the genitals?
no [ ] yes [ ] Chronic or recurrent problems with diarrhea, constipation or abdominal pain?
no [ ] yes [ ] Any convulsions or other problems with the nervous system?
no [ ] yes [ ] Eczema, hives, psoriasis or any other skin condition?
no [ ] yes [ ] Has this child ever been anemic?

Please list any other medical problems:
____
____
____
____

F. DEVELOPMENT/BEHAVIOR

___________ At what age did this child sit alone?
___________ At what age did he/she walk alone?
no [ ] yes [ ] Did he/she say any word by 18 months old?
How does this child compare with others his/her age? Ahead, behind, other:___________________________
no [ ] yes [ ] Does he/she have any trouble sleeping?
___________ What grade in school (or "daycare") is he/she in?
no [ ] yes [ ] Has he/she had any trouble in school /daycare?
no [ ] yes [ ] Does he/she get along with other children?
no [ ] yes [ ] Reactions to any immunizations? Circle if this child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, discipline problems, other:___________________
____

G. SAFETY/ENVIRONMENT

Do you live in a private house, apartment, mobile home, other?
no [ ] yes [ ] Do you know the hottest temperature of the water in your pipes?
no [ ] yes [ ] Is there a working smoke alarm on each floor?
no [ ] yes [ ] Does this child always use a car seat/seat belt when riding in a car?
no [ ] yes [ ] Are there any smokers in the household?
no [ ] yes [ ] Are there any guns in the house?
no [ ] yes [ ] Are there any problems with the condition of your home? (peeling paint, bad wiring, rats/mice, insects, bad plumbing, etc.)
no [ ] yes [ ] Does this child always wear a helmet when riding a bicycle or roller-blading?

COMMENTS:
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