

PEDIATRIC HISTORY

Reason for your child's visit today: (chief complaint) _____

Medical History: (please check box if your child has or has had the following)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Trouble seeing | <input type="checkbox"/> Trouble Hearing | <input type="checkbox"/> Frequent Ear Infections/Cold |
| <input type="checkbox"/> Trouble Talking | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Trouble Breathing |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bronchitis/Asthma | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Frequent Abdominal Pain |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Frequent Vomiting | <input type="checkbox"/> Seizures | <input type="checkbox"/> Frequent Constipation |
| <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Trouble with coordination | |

Please give the dates of those marked as well as hospitalizations or surgeries: _____

Medications (include vitamins and herbals):

Name: _____	Strength _____	Amount/day: _____
Name: _____	Strength _____	Amount/day: _____
Name: _____	Strength _____	Amount/day: _____

Has your child had an unusual reaction to any medications? Yes No, if yes what? _____

Allergies: _____

Is your child up to date on immunizations? Yes No

Has your child had any unusual reactions to any immunizations? Yes No, if yes what? _____

If any blood relative of the child has one of the following, please check:

	Father	Mother	Sister	Brother	Father's parents	Mother's parents
Asthma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Cancer, Type _____	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____
Kidney Problems	_____	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____	_____
TB	_____	_____	_____	_____	_____	_____
Chemical Dependence	_____	_____	_____	_____	_____	_____
Other, Explain _____	_____	_____	_____	_____	_____	_____

Was there anything unusual about this pregnancy, labor, delivery or problems during hospital stay? _____

Did you have any concern about your child's development, school performance, or behavior? _____

Are there smokers living in the home? Yes No

Guardian Name _____

Date _____

