Patient History

Name________________________ Date__________
Address____
Chart #______________ DOB:___________ Sex________
Mother's Name_____________________ Age___________
Occupation____
Father's Name_____________________ Age___________
Occupation____
If adults in the household work outside the home, what child care arrangements are made for this child?

____

PREGNANCY AND BIRTH

1. Mother's age at birth ______________
2. Did mother have any illness during pregnancy? Yes/No
3. Any medications other than vitamins and iron? Yes/No
4. Was the baby on time? Yes/No
5. What was the birth weight? _______
6. Did the baby have any trouble starting to breathe? Yes/No
7. Did the baby have any trouble in the hospital? (Jaundice, infections, other?) Yes/No

If so, what kind?

____

PAST MEDICAL HISTORY

1. Where has your child gone for check ups until now? _____
2. Date of last check up: ______________
3. Date of last dental check up: ______________
4. Has your child had allergic reactions to any medications, foods, insect bites? Yes/No

Which ones? ______________________________________

5. Has your child had reactions to immunizations? Yes/No

Which ones? ______________________________________

6. Any hospitalizations other than for birth? Yes/No

For What? _______________________________________

7. Any serious injuries? Yes/No

What kind? _______________________________________

8. Are any medications taken regularly? Yes/No

Which ones? ______________________________________

FAMILY HISTORY

1. Are the child's parents both in good health? Yes/No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others
3. List age, sex and general health of brothers and sisters:

____
____

4. Have any of your children died? Yes/No

FEEDING AND NUTRITION

1. Is your child's appetite usually good? Yes/No
2. Is it good now? Yes/No
3. Was there severe colic or any unusual feeding problems during the first 3 months? Yes/No
4. Do any foods disagree with him/her? Yes/No
5. For the first 6 months, is or was he/she breast-fed or bottle-fed? (Circle one)
6. If still on formula, which one do you use?_____________

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REVIEW OF SYSTEMS

1. Has your child had frequent ear infections Yes/No
2. Any eye problems? Yes/No
3. Has he/she had any problems with teeth? Yes/No
4. Does he/she have frequent colds or sore throats? Yes/No
5. Is there asthma, pneumonia, or recurrent cough? Yes/No
6. Does he/she have a heart murmur or any heart problems? Yes/No
7. Any problems with urinations? Yes/No
8 Any problems with diarrhea or constipations? Yes/No
9. Have there been any convulsions or other problems with the nervous system? Yes/No
10. Any eczema, hives or other skin conditions? Yes/No
11. Has your child ever been anemic? Yes/No
12. Please list any other medical problems:

____
____
____

DEVELOPMENT/BEHAVIOR

1. At what age did your child sit alone? _______
2. At what age did he/she walk alone? _______
3. Did he/she say any words by the time he/she was 1 ½ years old? _______
4. How does the child compare to others his/her age?

____

5. Does he/she have any trouble sleeping? Yes/No
6. What grade is he/she in? _______
7. Has he/she had any trouble in school? Yes/No
8. Does he/she get along with other children? Yes/No
9. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyper-activity, nightmares, speech problems, problems with discipline, others.______________________

SAFETY/ENVIROMENT

1. Do you live in a private house, apartment, mobile home, other? (Circle One)
2. Do you know the hottest temperature of the water in your pipes? Yes/No
3. Is there a working smoke alarm on each floor in the house? Yes/No
4. Does your child always use a car seat/seat belt when riding in the car? Yes/No
5. Are there any smokers in the household? Yes/No
6. Are there any problems with the condition of your home (peeling paint, insects, rats or mice)? Yes/No
7. Does your child always wear a helmet when riding his/her bicycle? Yes/No

DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes/No
If yes, please provide a copy to the nurse