Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Pediatric History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

FAMILY MEDICAL HISTORY

Please mark all conditions the PATIENT'S family has had:

○ **FAMILY HISTORY UNKNOWN** ○ **NO FAMILY MEDICAL HISTORY**

Mother	Father	Sister	Brother	
○	○	○	○	ADD / ADHD
○	○	○	○	Alcoholism
○	○	○	○	Allergies (Seasonal)
○	○	○	○	Allergies (Food)
○	○	○	○	Allergy to Penicillin
○	○	○	○	Anemia
○	○	○	○	Aneurysm
○	○	○	○	Anxiety Disorder
○	○	○	○	Arrhythmia
○	○	○	○	Asthma
○	○	○	○	Autism / Asperger's
○	○	○	○	Bipolar Disorder
○	○	○	○	Bleeding Disorder
○	○	○	○	Bronchitis (Chronic)
○	○	○	○	Cancer (Bone)
○	○	○	○	Cancer (Breast)
○	○	○	○	Cancer (Leukemia)
○	○	○	○	Cancer (Lymphoma)
○		○		Cancer (Ovarian)
○	○	○	○	Cancer (Skin)
○	○	○	○	Cancer (Thyroid)
○	○	○	○	Cancer (Other)
○	○	○	○	Celiac Disease
○	○	○	○	Chromosomal Disorder
○	○	○	○	Clotting Disorder
○	○	○	○	Congenital Heart Disease
○	○	○	○	Congestive Heart Failure
○	○	○	○	Crohn's Disease
○	○	○	○	Deafness
○	○	○	○	Depression
○	○	○	○	Diabetes (Adult Onset)
○	○	○	○	Diabetes (Juvenile Onset)
○	○	○	○	Down Syndrome

Mother	Father	Sister	Brother	
○	○	○	○	Eczema
○	○	○	○	Epilepsy
○	○	○	○	Gallbladder Disease
○	○	○	○	GERD (Gastroesophageal Reflux)
○	○	○	○	Hearing Loss
○	○	○	○	Heart Disease
○	○	○	○	Heart Murmur
○	○	○	○	Hypercholesterolemia (High Cholesterol)
○	○	○	○	Hypertension (High Blood Pressure)
○	○	○	○	Hypertrophic Cardiomyopathy
○	○	○	○	Hypoglycemia
○	○	○	○	Inflammatory Bowel Disease
○	○	○	○	Kidney Disease
○	○	○	○	Kidney Stones
○	○	○	○	Migraines / Headaches
○	○	○	○	Mitral Valve Prolapse
○	○	○	○	MTHFR Mutation
○	○	○	○	Multiple Sclerosis
○	○	○	○	Muscular Dystrophy
○	○	○	○	Myocardial Infarction / Heart Attack
○	○	○	○	Overweight / Obesity
○	○	○	○	Osteoporosis
○	○	○	○	Peptic Ulcer Disease
○	○	○	○	Scoliosis
○	○	○	○	Seizures
○	○	○	○	Strabismus
○	○	○	○	Stroke
○	○	○	○	Sudden Death Syndrome
○	○	○	○	Suicide
○	○	○	○	Thyroid Disease
○	○	○	○	Ulcerative Colitis
○	○	○	○	Urinary Tract Infections (UTI)

SOCIAL HISTORY

Who lives in the house with the child *(mark all that apply)***?**

- parents
- mother
- father
- foster parents
- brother
- brothers
- sister
- sisters
- grandmother
- grandfather
- aunt
- uncle
- lives alone
- other

Parent marital status:

single | married | separated | divorced | widowed

Custody: parent | shared custody | guardian | foster parent | grandparent

Childcare arrangement *(other than school)*:

babysitter / nanny | live-in nanny | grandparent | other relative

Does the child go to daycare? yes | no

Tobacco Smoke Exposure:

NONE

Please mark who smokes indoors:

mother | father | family member | caregiver

Please mark who smokes outside the house:

mother | father | family member | caregiver

Does the patient smoke?

currently (every day) | currently (some days) | in the past | never

Languages spoken at home *(mark all that apply)*:

- English
- Arabic
- Chinese
- Dutch
- Farsi
- French
- German
- Gujarati
- Hindi
- Italian
- Kannada
- Korean
- Marathi
- Russian
- Spanish
- Tagalog
- Tamil
- Telugu
- Thai
- Urdu
- Vietnamese

Pets:

- NONE
- dog(s)
- cat(s)
- bird
- fish
- gerbil
- hamster
- horse
- rabbit
- reptile
- turtle

SURGICAL HISTORY

*Please mark all surgeries your child has had. If none, mark "***Patient has had NO SURGERIES***."*

- ◯ **Patient has had NO SURGERIES**
- ◯ appendix removed
- ◯ broken bone(s) / fracture(s)
- ◯ chiari decompression
- ◯ ear tube(s) inserted
- ◯ heart surgery
- ◯ hernia repair
- ◯ surgery for brain tumor
- ◯ tethered cord release
- ◯ tonsils and adenoids removed
- ◯ vp shunt
- ◯ other type of surgery

BIRTH HISTORY

Patient was born: on time ◯ premature ◯ late ◯

Delivery was: vaginal delivery ◯ cesarean section ◯

Birth weight:

lbs				1 ◯	3 ◯	5 ◯	7 ◯	9 ◯
				2 ◯	4 ◯	6 ◯	8 ◯	10 ◯
oz	0 ◯	2 ◯	4 ◯	6 ◯	8 ◯	10 ◯	12 ◯	14 ◯
	1 ◯	3 ◯	5 ◯	7 ◯	9 ◯	11 ◯	13 ◯	15 ◯

Did mom have any problems with this pregnancy? yes ◯ no ◯

Did baby have any problems after birth? yes ◯ no ◯

Did baby stay in the hospital after mom went home? yes ◯ no ◯

Feeding style: breast ◯ bottle ◯ both ◯

If breast fed, number of months:

1-5 ◯	11-15 ◯	21-25 ◯	31-35 ◯
6-10 ◯	16-20 ◯	26-30 ◯	36 or more ◯

PAST MEDICAL HISTORY

Has your child ever been hospitalized? yes ◯ no ◯

Does your child have any chronic or serious medical condition(s)? yes ◯ no ◯

Has your child had any serious accidents or injuries? yes ◯ no ◯

How is your child's development compared to other children his / her age? average ◯ faster ◯ slower ◯

Immunizations: child has had none ◯ some ◯ all immunizations are up-to-date ◯

Child has a history of *(mark all that apply)*:

- ◯ autism
- ◯ bleeding disorder
- ◯ brain tumor
- ◯ congenital heart defect
- ◯ genetic disorder
- ◯ hydrocephalus
- ◯ migraines
- ◯ neurofibromatosis
- ◯ prematurity
- ◯ seizure disorder
- ◯ spina bifida