Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Pediatric History

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

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

BIRTH HISTORY

Patient was born: on time ◯ premature ◯ late ◯

Delivery was: vaginal delivery ◯ Cesarean section ◯

Birth weight:

lbs: 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

oz: 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 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 ◯ 6-10 ◯ 11-15 ◯ 16-20 ◯ 21-25 ◯ 26-30 ◯ 31-35 ◯ 36 or more ◯

SURGICAL HISTORY

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

- ◯ **Patient has had NO SURGERIES**
- ◯ tonsils and adenoids removed
- ◯ hernia repair
- ◯ appendix removed
- ◯ ear tube(s) inserted
- ◯ heart surgery
- ◯ broken bone(s) / fracture(s)
- ◯ other type of surgery

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 ◯

SOCIAL HISTORY

Child lives with (mark all that apply):
both parents ◯ mother only ◯ father only ◯ grandparent(s) ◯ foster parent ◯ other relative ◯ step parent(s) or parent's partner ◯ other ◯

Number of siblings? 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8+ ◯

Does anyone in the family smoke? yes ◯ no ◯

Does the family have any pets? yes ◯ no ◯

Academic performance of child:
not in school ◯ remedial / special ed ◯ below average ◯ average ◯ above average ◯

Is there any violent behavior in the family? yes ◯ no ◯

FAMILY MEDICAL HISTORY

Please indicate if PATIENT'S FAMILY has had any of the following.

◯ **Family History Unknown**

Mother	Father	Sister	Brother	
◯	◯	◯	◯	Attention Deficit Disorder
◯	◯	◯	◯	Asthma
◯	◯	◯	◯	Autism
◯	◯	◯	◯	Cancer
◯	◯	◯	◯	Diabetes
◯	◯	◯	◯	Drinking / Drug Problems
◯	◯	◯	◯	Heart Problems
◯	◯	◯	◯	High Blood Pressure
◯	◯	◯	◯	Mental Illness
◯	◯	◯	◯	**None of the Above**