*PEDIATRIC PRACTICES OF NORTHEASTERN PENNSYLVANIA*

## Patient History

Patient Name:_____ Birth Date:_____ Date:_____

Name all persons living in the patient's home at the present time.

| Name | Age | Relationship | Medical Concerns |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Birth History

Where was the patient born? Birth Weight

Was the patient born: ❑ At full term ❑ Premature How many weeks Premature?

How many days did the patient stay in the hospital after birth?

Did the patient have any medical problems following birth?

Were there any problems with labor or delivery?

Type of delivery: ❑ Vaginal ❑ Cesarean Section?

During the pregnancy with this child, did the mother: (check all that apply)

❑ Smoke?

❑ Drink alcohol or take drugs?

❑ Have any illness? Describe: _____

_____

❑ Take medications or hormones? Describe: _____

_____

**Maternal Statistics**

How many

_____Pregnancies

_____Children born full term

_____Children born premature

_____Abortions or Miscarriages

has this patient's mother experinced?

_____How many living children does this patient's mother have?

***(Please complete Family History information on reverse side)***

## Family History

Patient Name: _____ Birth Date: _____ Date: _____

Check if any of the patient's parents, brothers, sisters, aunts, uncles or grandparents have had any of the following:

Birth Defects: (Specify which and who)

_____

Blood Disorders: _____

___ Hemophilia
___ Von Willebrand Disease
___ Sickle Cell Disease or Trait
___ Factor V Leiden
___ Other blood problems
(specify which and who)

_____

_____

Bone: _____

___ Rheumatoid Arthritis
___ Hip Dysplasia
___Other (specify which and who)

_____

Brain: _____

___ Developmental Delay
___ Cerebral Palsy
___ Intellectual Disability
___ Seizures/Epilepsy
___ Alzheimers
___ Stroke
___ Other (specify which and who)

_____

Eye: _____

___ Amblyopia
___ Strabismus

Cancer: (specify which and who)

_____

_____

_____

Diabetes: _____

___ Type I
___ Type II
___ Unknown

Kidney Disease: (specify which and who)

_____

_____

_____

Lupus: _____

Metabolic Disorders: (specify which and who)

_____

_____

Psychiatric: _____

___ Depression
___ Bipolar
___ ADD or ADHD
___ Substance Abuse
___ Alcohol dependence

Eczema: _____

_____

Gastrointestinal: _____

___ Celiac Disease
___ Crohns Disease
___ Ulcerative Colitis
___ Lactose Intolerance
___ Other _____

_____

_____

Hearing Loss: _____

___ From Birth
___ Acquired

Heart: _____

___ Heart attacks before the age of 60
___ High Blood Pressure
___ Congenital Heart Disease (specify which and who) _____
___ High Cholesterol or Triglycerides
___ Heart Murmurs
___ Sudden Cardiac Arrest
___ Other _____

_____

Immunodeficiencies (specify which and who)

_____

_____

Infectious: _____

___ Tuberculosis
___ Hepatitis B
___ Hepatits C
___ HIV
___ Other (specify which and who)

_____

Gynecological: _____

___ Infertility
___Miscarriage
___ Ovarian Cysts
___ Endometriosis

Respiratory: _____

___ Cystic Fibrosis
___ Asthma
___ SIDS
___ Allergies
___ Environmental/Airborne
___ Food
___ Medications
___ Smoker/Tobacco Use

Thyroid Problem: _____

___ From Birth
___ Acquired after birth
___ Other Endocrine Conditions (specify which and who _____

*! ! ! If your child is less than 1 month old, stop here ! ! !*

## Patient's Health History

Patient Name:_____ Birth Date:_____ Date:_____

Is the patient transferring care from another primary healthcare provider? ❑ No ❑ Yes

Provider's Name: _____ Group/Practice Name:_____

Type of Provider: ❑ Doctor ❑ Physician's Assistant ❑ Nurse Practitioner Location:_____

Other than at birth, has the patient been hospitalized? ❑ No ❑ Yes

Reason: _____

Location: _____ Age:_____

Has the patient had any surgery? ❑ No ❑ Yes Describe: _____

Has the patient ever had x-rays? ❑ No ❑ Yes Describe: _____

Is the patient allergic to any of the following: (Please list type of reaction)

Medications ❑ No ❑ Yes

Injections ❑ No ❑ Yes

Foods ❑ No ❑ Yes

Other ❑ No ❑ Yes_____

Does the patient take: ❑ Vitamins ❑ Iron ❑ Fluoride ❑ Other Medications _____

Has the patient ever had any of the following: (check as many as apply)

- ❑ Anemia
- ❑ Asthma
- ❑ Allergic rhinitis
- ❑ Atopic Dermatitis (Eczema)
- ❑ Urinary Tract Infections
- ❑ Pneumonia
- ❑ Croup
- ❑ Seizures
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Hepatitis or Jaundice
- ❑ Arthritis
- ❑ Diabetes
- ❑ Strep Throat or Scarlet Fever
- ❑ Ear Infections (more than 3 in 1 year)
- ❑ Broken Bones
- ❑ Head Injuries
- ❑
- ❑ Cuts Requiring Sutures
- ❑ Loss of Consciousness
- ❑ Accidentally Taken Medications or Poison
- ❑ Vision Problems ➡ ❑ Wears Glasses
- ❑ Hearing Problems
- ❑ Frequent Headaches
- ❑ Frequent Nose Bleeds
- ❑ Chronic Cough
- ❑ Frequent Stomach Ache
- ❑ Frequent Vomiting
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Bed Wetting
- ❑ Dental Problems
- ❑ Chicken Pox

Other _____

*(-continued on reverse side)*

## Patient's Health History, continued

Patient Name:_____ Birth Date:_____ Date:_____

Was there any delay in the patient's learning to: ❑ Sit ❑ Walk ❑ Talk

Does the patient have difficulty in school with: ❑ Not in School ❑ Learning ❑ Behavior ❑ Other _____

How many days of school has the patient missed in the past 6 months? _____

Describe the patient's behavior by marking the appropriate category:

| | Major Problem | Minor Problem | No Problem |
|---|---|---|---|
| Short Attention Span | ❑ | ❑ | ❑ |
| Cannot Sit Still | ❑ | ❑ | ❑ |
| Aggressive | ❑ | ❑ | ❑ |
| Unusually Quiet | ❑ | ❑ | ❑ |
| Overly Active | ❑ | ❑ | ❑ |
| Extremely Poor Looser | ❑ | ❑ | ❑ |
| Difficulty Getting Along With Others | ❑ | ❑ | ❑ |

I would like to discuss the following concerns: _____