PEDIATRIC HISTORY INFORMATION

Patient Name: _____

PREGNANCY & BIRTH

Mothers age at pregnancy? _____
Any Illness during Pregancy Yes/No _____
Medications during pregnancy (exclude vitamins and iron) Yes/No
Smoking, Alcohol, or street drugs during pregnancy Yes/No
Was baby early/late/on time
Type of delivery Vaginal/Cesarean
Birth Weight _____
Birth Length _____
Complications at delivery _____
Problems with baby at Birth? Breathing Yes/No Jaundice Yes/No
Problems soon after birth Yes/No

PAST MEDICAL HISTORY

Allergic reaction to Medication Yes/No
Allergic reaction to Food Yes/No
Allergic reaction to Animals/Insects Yes No
Immunizations up to date Yes/No
Do you have a record of immunizations Yes/No
Hospitalization (when-where-why) Yes/No _____
Serious Injuries (when-where-why) Yes/No _____

FEEDING AND NUTRITION

Food Allergies Yes/No _____
Appetite usually good Yes/No
Colic or feeding problems during first 3 months Yes/No
Breast Fed Yes/No Number of months _____
Formula Yes/No Brand _____
Vitamins Yes/No _____
Special Diet Yes/No _____

Siblings

_____
_____
_____
_____

FAMILY MEDICAL HISTORY

(F) Father (M) Mother (B) Brother (S) Sister
(MM) Mothers Mother (MF) Mothers Father
(MA) Mothers Aunt (MU) Mothers Uncle
(FM) Fathers Mother (FF) Fathers Father
(FA) Fathers Aunt (FU) Fathers Uncle

Anemia/Blood Dis _____
Asthma _____
Mental Retardation _____
Drug Problem _____
Alcoholism _____
Cancer _____
Aids _____
Cystic Fibrosis _____
Musc. Dystrophy _____
Tuberculosis _____
Arthritis _____
Epilepsy / Seizures _____
Heart Disease _____
High Blood Pressure _____
Cholesterol Problem _____
Migraine _____
Sudden Infant Death _____
Birth Defects _____
Early Deafness _____
Diabetes _____