PEDIATRIC PATIENT HISTORY

Date of Initial Visit _____

Confidential record; Information contained here will not be released except when you have authorized us to do so.

Dear Parent or Guardian, Please fill out this form and bring it with you at the time of your child's appointment. Thank you.

Last _____ First _____ Date of birth_____ Age _____ Grade _____

Mailing address_____

Telephone_____ Mother's Name_____ Occupation_____

Father's Name_____ Occupation_____ Employer_____

Emergency contact person _____ Relationship_____ Phone number_____

Primary Care Provider _____ Phone number_____

Referring Physician _____ Phone number_____

Would you like a copy of this report sent to the Primary Care Provider and Referring Provider _____

Please describe your child problem _____

_____

Current Medications _____

Previous Medications with no benefit _____

Side Effects _____

History of smoking, alcohol, or substance abuse _____

Please circle Yes or No for any symptoms you or your child may be experiencing

Yes	No	Recurrent ear infections	Yes	No	Mouth breathing	Yes	No	Palate itch
Yes	No	Frequent colds	Yes	No	Itchy nose	Yes	No	Night cough
Yes	No	Sinusitis	Yes	No	Runny nose	Yes	No	Wheezing
Yes	No	Headaches	Yes	No	Hives	Yes	No	Itchy eyes
Yes	No	Easily tired	Yes	No	Eczema	Yes	No	Puffy eyes
Yes	No	Nose Bleeds	Yes	No	Boils	Yes	No	Red eyes
Yes	No	Sniffling	Yes	No	Frequent sore throats	Yes	No	Stomach ache
Yes	No	Repetitive sneezing	Yes	No	Throat clearing	Yes	No	Recurrent fever

Please list any other symptoms not listed above_____

Please write an **X** next to any of the following that you have noticed triggers or worsening problems your child's problem

	Cats		Food (milk, eggs, citrus, etc)		Emotions		Fall
	Dogs		Tobacco smoke		Paint		Winter
	Dusting/cleaning		Drugs		Aerosol sprays		
	Weather changes		Grass cutting		Spring		
	Exercise		Cooking odors		Summer		

Please write an **X** any of the following problems that your child has experienced, age, when it started and stopped

	Colic		Runny or stuffy nose
	Spitting up		Asthma
	Recurrent Diarrhea		Chronic Cough
	Hives		Eczema

FAMILY HISTORY – Please complete the list below to the best of your knowledge

Family member	Age	Eczema	Food	Allergies	Asthma	Hives	Hayfever
Father							
Mother							
Sister/brother							
Sister/brother							
Sister/brother							
Other family member							

Are there any blood relatives who have or had?

Yes	No	Emphysema
Yes	No	Tuberculosis
Yes	No	Death in infancy
Yes	No	Bleeding tendency
Yes	No	Cystic Fibrosis

Has your child had any previous hospitalization and/or operations?

Date	Procedure	Date of last chest x-ray

Has your child ever been diagnosed with?

Yes	No	Measles	Yes	No	Chicken pox
Yes	No	Mumps	Yes	No	Whooping cough
Yes	No	Recurrent ear infections	Yes	No	Chronic Bronchitis
Yes	No	Pneumonia Hepatitis			

Date of last hearing test _____

List any drugs causing a reaction_____

List any food causing a reaction_____

List any reaction to stinging insects_____

IMMUNIZATION - Please write in the date below

	DPT		Varicella		Pneumococcal (Pneumonia)
	Polio		HIB		List any others & date below
	Measles		Hepatitis B Vaccine		
	Rubella		Meningococcal		
	Tuberculin result _____		Influenza		

BIRTH AND PAST HISTORY

Type of delivery_____ Birth weight_____ Complications_____

Breast feed _____YES _____NO How long? _____ Formula (bottle _____

BEHAVIOR AND PSYCHO-SOCIAL - Please write an **X** in the box next to your response

	Timid		Aggressive		Tense		Calm
	Shy		Forward		Relaxed		Introvert
	Happy		Depressed		Friendly		Extrovert
	Dependent		Independent		Unfriendly		
	Quiet		Bustling		Anxious		

ENVIRONMENT – Please check or answer the appropriate response below

Where does the child spend most of his/her time during the week day? _____

Where does the child spend most of his/her time during the weekend? _____

What type of house? _____

What age is the house? _____

How long have you lived in the house? _____

Dose the house have Air condition? _____

What type of heating system is in the house? _____

Does the house have a Humidifier? _____ Air Filter? _____

Does anyone in the house smoke or vape _____

Do you have any pets? _____ If yes, what kind _____

Where do the pets stay and sleep? _____

Is your cellar finished? _____ Damp? _____ Musty? _____

Is your child's bedroom his or her own _____ or shared? _____

What type of flooring? _____Wall to wall carpets _____ Area rugs _____ Linoleum _____ Wood _____ Ceramic

What type of mattress? _____ How old is the mattress? _____

What type of pillow? _____Feather _____ Foam _____Kapok _____ Polyester _____ Other

Are there any stuffed animals in the bedroom? _____

What type of window coverings are in the child's bedroom? _____ Drapes _____Curtains _____Shades _____Blind

Does your child have? _____ Bookcases _____ Wall hangings _____ Plants

How often is the bedroom cleaned? _____