Premier Pediatrics

Pediatric Patient History

Child's name	Age	D.O.B.	M F	Date

Birth & Development

Did the mother have any problems during pregnancy?
Yes No

If yes, please explain:

Baby's condition at birth:
[ ] Good [ ] Fair [ ] Poor

Birth weight:

Did the baby have any breathing problems at birth?
Yes No

Type of delivery: Vaginal C-section

Did the baby become jaundiced?
Yes No

Did the baby go home from the hospital with the mother?
Yes No

Birth to One Year

Breast fed: Yes No How long?
Formula: Yes No What kind?
Colic: Yes No How old?

At what age did child sit?

Walk?

Talk?

One Year and Older

Good appetite? Yes No

Habits/Behavior (*Please check ✓*) :
[ ] Nail biting [ ] Thumb sucking
[ ] Nightmares [ ] Bad temper
[ ] Bedwetting [ ] Disobedient
[ ] Speech problems [ ] Holding breath
[ ] Jealous [ ] Irritable
[ ] Can't toilet train [ ] Other

Medical History

General Health: [ ] Good [ ] Fair [ ] Poor

Allergies: Yes No
[ ] To medications? (*Please list*)

[ ] To foods/other? (*Please list*)

Type of allergic reaction:
[ ] Rash [ ] Hives [ ] Respiratory Problems

Recurring medical problems (*Please check ✓*):
[ ] Diaper rash [ ] Fainting
[ ] Colds/Respiratory infections [ ] Ear infection
[ ] Seizures/Convulsions [ ] Sore throats
[ ] Stomach problems

Childhood diseases (*Please check ✓*):
[ ] Chicken pox [ ] Rubella
[ ] Measles [ ] Scarlet fever
[ ] Mumps [ ] Whooping cough

Hospitalizations/Surgeries/ER Visits (*List reasons & dates*):

Immunizations up to date? (*Please check ✓*)
[ ] Complete
[ ] Partial
[ ] None

Family History

Has anyone in the family ever had the following? (*Please check ✓ and state relationship to child*):

[ ] SIDS (Sudden Infant Death Syndrome) ________
[ ] Asthma ________
[ ] Allergies ________
[ ] Diabetes ________
[ ] Cancer ________
[ ] Drug/Alcohol abuse
[ ] Epilepsy ________
[ ] Mental illness ________
[ ] Sickle cell disease ________
[ ] Disabilities ________
[ ] Very high cholesterol ________
[ ] Heart attack before age 55

Siblings (*Please list*):

Does anyone in the household smoke?
Yes No

Do you or friends/family have a pool?
Yes No

Has your child been exposed to lead (i.e., in paint, older home, etc.)?
Yes No