alivation HEALTH

Pediatric History

Patient Name: _____ Date: _____

Date of Birth _____ Age _____ Race _____

Birth Weight _____ Birth Length _____ Preferred Pharmacy _____

Pregnancy: Any complications during this child's pregnancy (bleeding, infection, toxemia)?

Labor: Any complications during this child's labor (breach, prolonged, slow heart rate in baby)?

Delivery: Any problems during this child's delivery (c-section, forceps, heavy bleeding, premature, late)?

Hospital: Any problems during this child's hospital stay (yellow jaundice, trouble with formula, infections)?

Allergies: Is the child allergic to: Antibiotics (list) _____
Medications: _____
Other _____

Operations: (list any operations the child has had and dates performed) _____

_____

Other hospitalizations and illnesses: _____

_____

Medications _____

Family History

	Age	Deceased	Alcoholism	Arthritis	Asthma	Bleeds Easily	Cancer	Diabetes	Epilepsy	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Migraine	Stroke	TB	Thyroid Disease	Other
Father																			
Mother																			
Bro/Sis																			
Bro/Sis																			
Bro/Sis																			
Bro/Sis																			

Please provide a copy of current immunization card to place on chart.

Signature: _____ Date: _____

Circle one: Mother, Father, or Legal Guardian

NAME: DOB:

REVIEW OF SYSTEMS:
Has this child had any of the following problems?:
(include both past and present)

GENERAL:

Anemia	Yes	No
Recent weight change	Yes	No
Thyroid problems	Yes	No
Diabetes or high blood sugar	Yes	No
Frequent fever or chills	Yes	No
Frequent large lymph glands or lumps	Yes	No

Other _____

SKIN:

Frequent rashes	Yes	No
Changing mole	Yes	No

Other _____

HEAD:

Frequent headaches	Yes	No
Visual problems (include glasses)	Yes	No
Glaucoma	Yes	No
Frequent dizziness	Yes	No
Fainting	Yes	No
Epilepsy or seizures	Yes	No
Weakness in arm or leg	Yes	No
Numbness	Yes	No
Frequent ear infections	Yes	No
Hearing difficulty	Yes	No
Ringing in ears	Yes	No
Frequent nosebleeds	Yes	No
Frequent nasal congestion	Yes	No
Difficulty swallowing	Yes	No
Persistent hoarseness	Yes	No

Other _____

LUNGS:

Severe shortness of breath	Yes	No
Asthma or emphysema	Yes	No
Frequent cough	Yes	No
Coughing up blood	Yes	No
Tuberculosis	Yes	No

Other _____

HEART:

High blood pressure	Yes	No
Rheumatic fever	Yes	No
Chest pain or pressure	Yes	No
Irregular heart beat	Yes	No
Swelling in legs	Yes	No

Other _____

GASTROINTESTINAL:

Indigestion or heartburn	Yes	No
Ulcers	Yes	No
Frequent abdominal pain	Yes	No
Vomiting blood	Yes	No
Hepatitis or liver problems	Yes	No
Gallbladder problems	Yes	No
Frequent diarrhea	Yes	No
Frequent constipation	Yes	No
Rectal problems or bleeding	Yes	No
Black tar-like bowel movements	Yes	No
Recent change in bowel habits	Yes	No

Other _____

URINARY:

Kidney or bladder infection	Yes	No
Kidney stones	Yes	No
Burning with urination	Yes	No
Difficulty passing urine	Yes	No
Difficulty controlling urine	Yes	No
Getting up at night to urinate	Yes	No
Blood in urine	Yes	No
Bedwetting	Yes	No

Other _____

GENITALIA:

Undescended testes	Yes	No

BEHAVIOR:

School Problems	Yes	No
Sleep difficulty	Yes	No
Nightmares / terrors	Yes	No
Unusual fears	Yes	No
Problems playing with other children	Yes	No
Poor appetite	Yes	No
Temper tantrums	Yes	No

DEVELOPMENT:

Age this child: _____
Sat up alone _____
Crawled Walked _____
Talked in phrases _____