

# Longs Peak Family Practice Pediatric History Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This child lives with  Mother  Mother/Father  Mother/Partner  Father/Partner  Grandparent/Other

## PRENATAL HISTORY

While pregnant, did the mother have: (please circle)

High blood pressure	Threatened Miscarriage	Kidney Disease	Toxemia
Bleeding or spotting	German Measles (Rubella)	Illness other than cold or flu	Premature Labor
			Gestational Diabetes

Were medications, herbs or supplements taken during pregnancy?  yes  no

If yes, what kind? \_\_\_\_\_

Was a fertility treatment used for this pregnancy?  yes  no

If yes, what kind? \_\_\_\_\_

## BIRTH HISTORY

Where was the baby born? \_\_\_\_\_

Was labor induced?  yes  no Was labor helped by medication?  yes  no Duration of labor: \_\_\_\_\_

Was baby born early: (less than 38 wks)  yes  no Was baby born late: (after 42 weeks)  yes  no

What was the method of delivery:  Spontaneous Vaginal  Forceps  Breech  Cesarean

Birth weight of baby: \_\_\_\_\_ Apgar score, if known \_\_\_\_\_

During the hospital stay, did the baby have any of the following: (please circle)

Jaundice	Convulsions	Rash
Antibiotic treatment	Blue Spells	Other Problems? _____

Did baby remain in hospital longer than mother?  yes  no How was baby fed?  Bottle  Breast

**\*\*PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES\*\***

## DEVELOPMENTAL HISTORY

At what age did the child: (please give age)

Hold up head _____	Sit unsupported _____	Walk _____	Toilet train _____
Roll over _____	Stand alone _____	Talk _____	Feed him/herself _____
			Dress him/herself _____

## PAST MEDICAL HISTORY

Has your child had: (please circle)

Chicken Pox	German Measles (Rubella)	Contusions	Fractures
Measles (Rubeola)	Meningitis	Poison ingestion	Blood transfusions
Mumps	Convulsions	Blood: anemia (iron deficiency, Sickle Cell, Thalassemia)	Operations

Hospitalizations  yes  no If yes, what illness and when? \_\_\_\_\_

Is your child currently taking any medications, vitamins or herbs?  yes  no

<u>Medications</u>	<u>Strength/dose</u>	<u>How often</u>
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_____	_____	_____
_____	_____	_____

Reaction to drug or foods (allergy)?  yes  no If yes, please explain \_\_\_\_\_

Any chronic or recurring pain?  yes  no If yes, please explain \_\_\_\_\_

## Eyes:

Visual Problems  yes  no  
Do eyes look crossed?  yes  no  
Wear glasses?  yes  no

## Ears:

Any hearing problems?  yes  no  
Three or more ear infections?  yes  no

## Nose:

Does child have frequent attacks of sneezing/rubbing nose?  yes  no  
Has the child had frequent nosebleeds?  yes  no

## Throat:

Does your child have three or more strep throat infections per year?  yes  no

**Heart:** Have you ever been told your child has:

- A heart murmur  yes  no
- High blood pressure  yes  no
- Heart defect  yes  no
- Does your child tire easily?  yes  no

**Abdomen:** Has your child ever had:

- Jaundice  yes  no
  - Blood in bowel movement  yes  no
  - Frequent abdominal pain  yes  no
  - Frequent vomiting or diarrhea  yes  no
  - Marked weight loss  yes  no
  - Difficulty with appetite or eating?  yes  no
- If yes, please explain \_\_\_\_\_

**Skin:**

- Any sensitivity or allergy?  yes  no
- Eczema or atopic dermatitis?  yes  no
- Acne?  yes  no

**Neurological:** Has your child ever had:

- Frequent headaches  yes  no
- Convulsions or seizures  yes  no
- Dizziness  yes  no
- Fainting  yes  no
- Breath holding  yes  no
- Temper tantrums  yes  no
- Concussion  yes  no

Are there concerns about physical, emotional or sexual abuse?  no  yes

Has your child begun puberty?  yes  no

**FAMILY HISTORY**

Mother- Age: \_\_\_\_\_ Current Health: \_\_\_\_\_ Past Health Problems: \_\_\_\_\_

Father- Age: \_\_\_\_\_ Current Health: \_\_\_\_\_ Past Health Problems: \_\_\_\_\_

Marital Status of Parents: \_\_\_\_\_

Other Children in Family:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ State of health \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ State of health \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ State of health \_\_\_\_\_

Is there a history of divorce?  no  yes

Does anyone smoke around your child?  no  yes

Are there any big stresses in your lives?  no  yes If yes, what? \_\_\_\_\_

Are there cultural or religious practices that might affect your child's care?  yes  no

If yes, please explain: (examples: blood transfusion, dietary rules) \_\_\_\_\_

Is there a history in the **family/blood relative** of: (please circle)

- |                                      |   |                                |
|--------------------------------------|---|--------------------------------|
| Tuberculosis                         | Hepatitis                               | Mental Disorder                |
| Diabetes                             | Heart disease, stroke, high cholesterol | Birth Defects, Genetic Defects |
| Asthma, hay fever, allergies, eczema | Cancer, what kind? _____                | Seizures                       |
|                                      |   | Other serious medical problems |

Are there any other concerns you would like to discuss? \_\_\_\_\_

\_\_\_\_\_

Parent Signature

Date

Provider Name

Date reviewed

**Lungs:** Has your child ever had:

- Bronchitis or pneumonia  yes  no
- Asthma/wheezing  yes  no
- Chronic cough  yes  no

**Kidney:**

- Has your child ever had a urinary tract infection?  yes  no
- Has there ever been blood in the urine?  yes  no
- Does your child ever wet the bed?  yes  no
- Does your child ever complain of burning or frequency of urination?  yes  no

**Extremities:** Has your child:

- Ever worn corrective shoes or braces?  yes  no
- Had weakness or paralysis of arms or legs?  yes  no
- A persistent limp?  yes  no

**Is your child:**

- Overactive  yes  no
- Impulsive  yes  no
- Lacking in self control  yes  no

Does your child have problems with:

- Peers  yes  no
- Siblings  yes  no
- Parents  yes  no
- Sleep  yes  no
- Attention span  yes  no
- Attending school  yes  no
- Learning  yes  no
- Mood  yes  no