PEDIATRIC HISTORY

Child's Name: _____ Age:_____ Today's Date: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Phone Number: _____ Father's Phone Number: _____

Child's Birth Date: ____ /____ /____ Birth Weight: _____ Current Weight: _____

Sex: MALE / FEMALE No. of Siblings : _____ Birth Length: _____ Current Length: _____

Type of Birth: NORMAL VAGINAL / FORCEPS / BREECH / CESAREAN / OTHER: _____

Birth Place: HOME / BIRTH CENTER or HOSPITAL (name): _____

Pregnancy / Delivery / Birth History: _____

_____

_____

_____

Problems During Pregnancy / Labor / Delivery: _____

_____

APGAR Scores: _____ / _____ At Birth Was There...: JAUNDICE (YELLOW) OR CYANOSIS (BLUE)

Congenital Anomalies / Defects: _____

Infant Feeding: BREAST BOTTLE FORMULA OTHER:_____

Hours of Sleep Per Night: _____ Quality of Sleep: GOOD FAIR POOR

Obstetrician /Midwife:_____
NAME LOCATED AT

Pediatrician / Family MD: _____
NAME LOCATED AT

Date of Last Visit to MD: _____ Purpose:_____

Immunization History: _____

Purpose of This Appointment: _____

Has Your Child Ever Been Treated on an Emergency Basis?: NO YES (Describe): _____

_____

At What Age Did the Child...

RESPOND TO SOUND _____ FOLLOW AN OBJECT WITH THEIR EYES _____ HOLD HEAD UP _____

SIT ALONE _____ CRAWL _____ STAND _____ WALK ALONE _____

Has Your Child Had... CHICKEN POX MUMPS MEASLES RUBELLA RUBEOLA WHOOPING COUGH

OTHER: _____

Has Your Child Ever Suffered From...

☐ DIZZINESS	☐ BACKACHES	☐ HEART TROUBLE	☐ CHRONIC EARACHES
☐ DIABETES	☐ TUBERCULOSIS	☐ HYPERTENSION	☐ COLDS / FLU
☐ ARTHRITIS	☐ HEADACHES	☐ ASTHMA	☐ ALLERGIES
☐ NEURITIS	☐ DIGESTIVE DISORDERS	☐ SINUS TROUBLE	☐ CONSTIPATION
☐ ANEMIA	☐ RHEUMATIC FEVER	☐ DIARRHEA	☐ ORTHOPEDIC PROBLEMS
☐ POOR APPETITE	☐ HYPERACTIVITY	☐ CONVULSIONS	☐ SUGAR CONCENTRATION
☐ BED WETTING	☐ WALKING PROBLEMS	☐ PARALYSIS	☐ BEHAVIORAL PROBLEMS
☐ FAINTING	☐ ARM PROBLEMS	☐ BROKEN BONES	☐ MUSCLE JERKING
☐ NECK PROBLEMS	☐ LEG PROBLEMS	☐ JOINT PROBLEMS	☐ "GROWING PAINS"
☐ RUPTURES / HERNIAS	☐ DRUG REACTIONS	☐ OTHER:	

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PEDIATRIC HISTORY

History of Surgery or Accidents:_____

_____

_____

_____

_____

_____

Medications: _____

Family Medical History: _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTORS TO ADMINISTER CARE AS SO DEEMED NECESSARY TO

(NAME)_____ SIGNED: _____ DATE: _____
SON / DAUGHTER

I ALSO REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT FEES ARE PAYABLE FOR SERVICES AS THEY ARE PERFORMED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

Signed: _____ Today's Date: _____

Who shall we bill? □ BILL ME □ BILL INSURANCE COMPANY, AND I'LL PAY MY PORTION WEEKLY □ OTHER

Parent's Insurance ID#: _____ Child's Insurance ID#: _____

Insurance Carrier Name: _____ (please provide card to receptionist)

IF YOUR CHILD HAD A FALL OR ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

Date of the accident or fall? _____ Have they been seen by any other physician since the accident? NO YES

Was your child in an automobile accident? NO YES Were they in the... REAR SEAT or FRONT SEAT?

If yes, were they in a... "SAFETY BUCKET" or BOOSTER SEAT Were they facing... FORWARD or BACKWARD?

Were they wearing a... LAP BELT / SHOULDER & LAP BELT (was the shoulder strap across the... NECK SHOULDER or UNDER THE ARM)

Was the impact on the REAR / FRONT / LEFT SIDE / RIGHT SIDE ?

Briefly describe the accident or fall: _____

_____

List any visible bumps, bruises, scrapes, cuts, etc. on your child caused by the accident or fall:_____

_____

Since the accident or fall does your child wake frequently at night? NO YES

Does s/he cry when a parent tries to change her/his sleeping position? NO YES Or lift / hold her/him? NO YES

Has your child become... IRRITABLE / RESTLESS / GRUMPY / LETHARGIC ?

Since the accident, describe any other changes in your child's eating habits, sleeping habits, bathroom habits, or disposition:

_____