Patient's Name:_____

Date of Birth:_____

Date of Visit:_____

A thru Z PEDIATRICS

New Patient History

Mother's Name:_____ Mother's Age: _____

Father's Name: _____ Father's Age: _____

A. PREGNANCY AND BIRTH

1. Mother's age at birth _____
2. Did Mother have any illness during pregnancy? ☐ Yes ☐ No
3. Did Mother take any mediations other than vitamins and iron? ☐ Yes ☐ No
4. Was the baby on time? ☐ Yes ☐ No
5. Was the baby delivered vaginally? ☐ Yes ☐ No
6. At what hospital was your baby delivered? _____
7. What was the baby's birth weight? _____
8. What was the baby's length at birth? _____
9. Did the baby have any trouble staring to breath? ☐ Yes ☐ No

B. PAST MEDIAL HISTORY

1. Where has your child gone for check-ups until now?

_____

2. Date of last check up?

_____

3. Date of last dental check up?

_____

4. Has your child had allergic reactions to any medications? Food? Insect bites? If yes, describe. ☐ Yes ☐ No

_____

5. Has your child had reactions to any Immunizations? If Yes, which ones? ☐ Yes ☐ No

_____

6. Any hospitalizations other than for birth? If yes, for what? ☐ Yes ☐ No

_____

7. Any serious injuries? If yes, what kind? Yes No

_____

8. Does your child take any medications regularly? If yes, which ones? ☐ Yes ☐ No

_____

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C. FEEDING AND NUTRITION

1. Is your child's appetite usually good? ☐ Yes ☐ No
2. Is it good now? ☐ Yes ☐ No
3. Was there severe colic or any unusual feeding problems during the first 3 months? ☐ Yes ☐ No

If yes, Explain: _____

4. Do any foods disagree with him/her? ☐ Yes ☐ No

If Yes, what? _____

5. For the first 6 months, is he/she breast fed or bottle fed? ☐ Bottle ☐ Breast
6. If he/she is still on formula? Which one do you use? _____
7. Does he/she take fluorides? ☐ Yes ☐ No

D. REVIEW OF SYSTEMS:

1. Has he/she ever had problems with their ears or hearing loss? ☐ Yes ☐ No
2. Has he/she ever had problems with their eyes? ☐ Yes ☐ No
3. Has he/she ever had problems with their teeth or gums? ☐ Yes ☐ No
4. Does he/she have frequent colds or sore throats? ☐ Yes ☐ No
5. Is there a history of asthma, pneumonia, or recurrent coughs? ☐ Yes ☐ No
6. Does he/she have a heart murmur or any heart problems? ☐ Yes ☐ No
7. Has he/she ever had problems with urination? ☐ Yes ☐ No
8. Has he/she ever had problems with diarrhea or constipation? ☐ Yes ☐ No
9. Has he/she ever had convulsions? ☐ Yes ☐ No
10. Has he/she ever had problems with eczema, hives, or other skin conditions? ☐ Yes ☐ No
11. Has he/she ever been anemic? ☐ Yes ☐ No

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E. DEVELOPMENT/BEHAVIORAL

1. At what age did he/she sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1.5 yrs. old? ☐ Yes ☐ No
4. How does this child compare to others his/her age?

_____

5. Does he/she have any trouble sleeping? ☐ Yes ☐ No
6. If the child is in school, what grade is he/she in? _____
7. If the child is in school, does he/she have any trouble in school? ☐ Yes ☐ No
8. Does he/she get along with other children? ☐ Yes ☐ No
9. Does your child have any of the following?

Hyperactivity?	☐ Yes	☐ No
Nail biting?	☐ Yes	☐ No
Thumb sucking?	☐ Yes	☐ No
Bed wetting?	☐ Yes	☐ No
Problems toilet training?	☐ Yes	☐ No
Nightmares?	☐ Yes	☐ No
Discipline issues?	☐ Yes	☐ No
Bad Temper?	☐ Yes	☐ No
Speech Problems?	☐ Yes	☐ No

F. SAFETY AND ENVIROMENT

1. Do you live in: ☐ House ☐ Apartment ☐ Other: _____
2. Do you know the hottest temperature of the water in your home? ☐ Yes ☐ No
3. Is there a working smoke alarm in each room? ☐ Yes ☐ No
4. Does your child always use a car seat? ☐ Yes ☐ No
5. Does anyone in your home smoke? ☐ Yes ☐ No
6. Are there any problems with the condition of your home like peeling paint, insects, rats or mice? ☐ Yes ☐ No

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G. SOCIAL HISTORY

1. Do both natural parents live at home? ☐ Yes ☐ No
2. Was the child adopted? ☐ Yes ☐ No
2. Is there a step-parent(s) involved in the child's life? ☐ Yes ☐ No
2. Does a parent provide fulltime care of the child at home? ☐ Yes ☐ No
3. Do grandparents help in the childcare? ☐ Yes ☐ No
4. Does a babysitter help in the childcare? ☐ Yes ☐ No
5. Does the child attend Daycare/Pre-school/School full time? ☐ Yes ☐ No
6. Does the child attend Daycare/Pre-school/School part time? ☐ Yes ☐ No
7. Please list all members of the child's household and their relationship. (If you need more space, please use blank space below)

First Name, Last Name	Relationship