Pediatric Medical and Surgical History-1

Name ____________ Date of Birth _________ Gender F M

Parent/Guardian ________________________________ Lives with _________________________________

Any special spiritual or religious needs? Yes No ____

Any special cultural needs? Yes No _______________________________

What language is spoken at home? _______________________________

Any **ALLERGIES** to medications, x-ray dyes, foods, or other substances? Yes No

____

____

____

Family Medical History (including heart disease before 55 yrs, TB, HIV, seizures, cancer diabetes, etc.)

	Date of birth	History
Mother		
Father		
Grandparent		
Sibling / other		

Birth History

Term ___ Premature ___ / Weeks___ Late ___ / Weeks ___ Birth Weight _________

Vaginal delivery ___ Cesarean section ____ Birth Length _________

Complications of Pregnancy: ________________________________

____

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____

New born complications ____ Injuries ____ special care ____________

Breathing problems ____ Medications ____ __________________

Seizures ____ _________ __________________

Jaundice ____ _________ __________________

Was he / she discharged from the hospital at the same time as his / her mother? YES NO

Pediatric Medical and Surgical History-2

__ Allergies	____ Constipation	____ Immune deficiency
__ Anemia	____ Cystic fibrosis	____ Kidney problems
__ Asthma	____ Epilepsy (seizures)	____ Lead poisoning
__ Attention problems	____ Eating disorders	____ Learning disorders
__ Bed wetting	____ Ear infections	____ Meningitis
__ Behavior problems	____ Eye problems	____ Pain (chronic or unusual)
__ Bleeding disorder	____ feeding problems	____ Pneumonia
__ Blood disorder (other)	____ Hearing problems	____ Prematurity
__ Cancer ______	____ Heart problems	____ Shot(immunization) reaction
__ Chronic lung disease (BPD)	____ Injuries ___________	____ sickle cell anemia
__ congenital disorder	____ Colic	

SURGERIES: ____

____

MEDICATIONS (including prescription drugs, fluoride, vitamins, and herbal products)

____________ ____________ ____________

____________ ____________ ____________

DEVELOPMENTAL HISTORY

__ Roll over	__ Walk holding on	ACTIVITIES
__ Sit unassisted	__ Waked alone	_dance _ gymnastics
__ Crawled	__ Spoke	_ swim _ soccer
__ Pulled to stand	__ Potty trained	_ baseball _ basketball
__ Stood alone		_ football _ bicycling
		others: _____ _______

Any special equipment or assisted devices? YES NO ____________________

Any specific developmental concerns? YES NO ____________________

HEALTH PROMOTION AND SAFETY

Are his / her immunizations up tp date as far as you know? YES NO NOT SURE

Does he / she wear a safety belt in the car? YES NO SOMETIMES

Does he / she were a bicycle helmet and/or other protective equipment? YES NO SOMETIMES

Are there firearms in the home? YES NO If so, is it loaded? YES NO Is the gun locked? YES NO
Is the ammunition stored separately? YES NO

Does your home have smoke detectors? YES NO Carbon Monoxide detectors? YES NO
Fire extinguisher? YES NO

Does your family have a fire safety plan including escape route, meeting place, and calling 911? YES NO

Have you discussed the following with your child? Drugs/alcohol/tobacco use? YES NO
(if appropriate for child's age) Puberty, menstruation (periods), etc. YES NO
Abstinence, safe sex, condoms, HIV? YES NO

Parent/Guardian/Patient ____________________ Date __________