DeVito Internal Medicine and Pediatrics

PEDIATRIC – MEDICAL HISTORY

Child's Last Name:_____ Child's First Name:_____
Birthdate:_____ Gender: M / F Ethnicity:_____
Child's Father:_____ Child's Mother:_____
Child's Brothers/Sisters (and DOB):_____
Doctor Who Delivered Child:_____
Facility and Location of child's birth:_____
Birth Wt:_____ Birth Length:_____ Birth Head Circ:_____
Delivery Type: Vaginal_____ or C-Section_____ Vacuum or Forceps assisted:_____
Full Term or Preterm (total weeks):_____
Was Child: Breast Fed Y / N If yes, how long?_____
Bottle Fed Y / N Formula name(s):_____

Pregnancy History (please answer Yes or No)

Smoking	Y / N	Medication(s)	Y / N	Drugs/Alcohol	Y / N
Bleeding	Y / N	High Blood Pressure	Y / N	Premature Labor	Y / N
Infections	Y / N	Toxemia	Y / N	Preeclampsia	Y / N

Other (explain)

Problems during his/her newborn period (please answer Yes or No)

Jaundice	Y / N	Breathing problems	Y / N	Infections	Y / N
Colic	Y / N	Feeding problems	Y / N		

Other (explain)_____

Developmental History

At what age did your child (approx): Sit up_____ Crawl_____ Walk_____ First Word_____

Family History (please answer Yes or No and indicate relationship to child)

		Relationship to Child
Asthma	Y / N	_____
Anesthetic reaction	Y / N	_____
Bleeding disorder	Y / N	_____
Cystic Fibrosis	Y / N	_____
Cancer (and type)	Y/ N	_____
Diabetes (type I or II)	Y / N	_____
Elevated cholesterol	Y / N	_____
Heart disease	Y / N	_____
Early/unexplained death	Y/ N	_____
Muscular Dystrophy	Y / N	_____
Seasonal allergies	Y / N	_____
Sickle Cell anemia	Y / N	_____
Thyroid disease	Y / N	_____

Other (explain)_____

Child's Allergies to Medication(s) (note reaction for each):_____

Allergies to Food(s) (note reaction for each):_____

Please list all medication currently taken for seasonal/other allergies:

Significant Illnesses/Injuries	Hospitalized?	How long?
_____	Y / N	_____
_____	Y / N	_____
_____	Y / N	_____
_____	Y / N	_____

Child's Medical History

Asthma	Y / N	Heart Surgery	Y / N
Pneumonia	Y / N	Anemia	Y / N
Chronic Cough	Y / N	Bleeding disorder	Y / N
Seasonal Allergies	Y / N	Diabetes	Y / N
Post-nasal drip	Y / N	Hepatitis	Y / N
Frequent 'colds'	Y / N	Chronic Constipation	Y / N
Ear infections	Y / N	Chronic Diarrhea	Y / N
Ear tubes	Y / N	Stomach Pain	Y / N
Nose bleeds	Y / N	Swollen painful joints	Y / N
Eye Surgery	Y / N	Chronic muscle aches	Y / N
Glasses	Y / N	Bedwetting > age 3	Y / N
Contacts	Y / N	Seizure Disorder	Y / N
Mouth Sores	Y / N	Headaches/Migraines	Y / N
Thyroid Disorder	Y / N	Urinary tract infections	Y / N
Heart Disease	Y / N	Learning Disorder	Y / N
Heart Murmur	Y / N	Behavioral Disorder	Y / N
Elevated Cholesterol	Y / N	ADHD	Y / N

Other (explain)_____

Child care outside the home (details):_____

Tests and Immunizations (you may provide a copy of child's most recent vaccination and/or chart records)

		Date of most recent test			Date of most recent test
Chest x-ray	Y / N		CBC	Y / N	
Fasting blood sugar	Y / N		Thyroid panel	Y / N	
Lipids (Cholesterol)	Y / N		Hearing test	Y / N	
Chemistry panel	Y / N		Vision test	Y / N	
Urine test	Y / N		TB (PPD) test	Y / N	

Other (details)_____

Girls only

Age at first menstrual period:_____ Date of last menstrual period:_____

Are periods regular? Y / N If no, please explain:_____

Symptoms w/ period? Y / N If yes, please explain:_____