WESTERN WAYNE PHYSICIANS

Pediatric Patient History

Child's Name_____ Age Today_____ Date_____

Previous Physician_____Referred By_____

BIRTH HISTORY: Adopted? Yes_____ No_____, If "Yes", is child aware? Yes_____ No_____

Date of Birth_____ Hospital_____ Birth Weight_____Length_____

Prenatal Problems? Yes_____ No _____, If "Yes", please list:_____

_____

Full-Term or Premature_____

Type of Delivery: Vaginal_____ C-Section_____

Regular Nursery? Yes_____ No_____

NICU or Special Care Nursery? Yes_____ No_____, If "Yes", reason:_____

_____

Problems After Birth or During First Week (0 – None)

Breathing Problems _____

Convulsions _____

Jaundice _____ If "Yes", was treatment needed?_____

Feeding Problems _____

Heart Problems _____

Hips _____

Other _____

Breast Fed (How long?)_____

Bottle Fed (Type(s) of Formula)_____

_____

SOCIAL HISTORY: Who Does Child Live With? Mother_____Father_____Both_____ Other_____

Mother's Name:_____ Age_____ Health_____

Occupation_____ Education (Last Grade)_____

Father's Name:_____ Age_____ Health_____

Occupation_____ Education (Last Grade)_____

Brother_____ Age_____ Health_____

Brother_____ Age_____ Health_____

Brother_____ Age_____ Health_____

Sister_____ Age_____ Health_____

Sister_____ Age_____ Health_____

Sister_____ Age_____ Health_____

Parents' Marital Status: Married_____ Divorced*_____ Never Married_____ Seperated_____

*If Divorced, who has legal custody?_____

Residence: City Name_____ House_____ Apartment_____ Flat_____ Mobile Home_____

Who Lives In Home?_____

Child's School_____ Grade_____ Grades: Above Avg._____ Avg._____ Poor_____

Preschooler: In Day Care? Yes_____ No_____, If "Yes" number of days per week_____

Developmental Milestones: Child Walked at Age_____ Few Words at Age_____

Toilet Trained at Age_____

Allergies_____ Current Medications_____

PAST MEDICAL HISTORY: (Check all that apply)

Roseola ("Baby Measles")	Bowel Problems	"Wheezing" or Asthma
Rubella ("German or 3-day Measles")	Menstrual Problems	Seizures
Rubeola ("Hard or 7-day Measles")	Fracture	Hives/Skin Problems
Mononucleosis	School Problems	Bed-wetting
Pneumonia	Mumps	Behavior Problems
Bladder Infection	Chicken Pox	Age of 1st period _____
Heart Murmur	Scarlet Fever	Sutures/"Stitches"
Diabetes	Strep Throat	Other_____
Fainting	Ear Infection	

Previous Hospitalization/ER Visits_____

Give Name of Hospital, Type of Problem, Child's Age. If None, Please Write None:

_____

_____

RISK FACTORS

Smokers in Home? Parents: Yes_____ No_____ / Sitter: Yes_____ No_____ / Grandparents: Yes_____ No____

Guns in Home? Yes_____ No_____, If "Yes", are they locks and unloaded?_____

Smoke Detector in Home? Yes_____ No_____

Do You Smoke: Yes_____ No_____ Drink Alcohol? Yes_____ No_____

FAMILY HISTORY

Medical Problems (Relatives of the Patient)

0 = None F = Father GP = Grandparent GGP – Great Grandparent

M = Mother S/B = Sister/Brother A/U = Aunt/Uncle

	0	M	F	S/B	GP	A/U	GGP	
Tuberculosis (T.B.)								
Allergy/Asthma								
Heart Attack Before Age 40								
Diabetes								
Hypoglycemic (Low Blood Sugar)								
Convulsions								
Hear Disorder								
Cancer								
Hypertension (High Blood Pressure)								
Arthritis								
Kidney/Bladder Disorder								
Stroke								
Bleeding Disorder								
Muscle Disorder								
Developmental Delay or Retardation								
Other								

History of Birth Defects _____

History of S.I.D.S._____

Signature of Informant_____ Date_____

Signature of Physician_____ Date_____