PEDIATRIC HEALTH HISTORY

New Patient, 1 year and older

HOSPITAL DRIVE PEDIATRICS

Patient Name:_____ Nickname:_____

Date of Birth:_____ Age_____

Place of Birth (city,state,country):_____

Prior Pediatrician: _____ City: _____

PREGNANCY/BIRTH INFORMATION:

1. Did mother have any illnesses, infections or other complications during the pregnancy with this child? ☐Yes ☐No

   If yes, please check which ones(s):

   ☐ Infection ☐ High Blood Pressure
   ☐ Diabetes ☐ Seizure
   ☐ Depression ☐ Ultrasound abnormality
   ☐ Other:_____

2. Did mother use any of the following during pregnancy? ☐Yes ☐No

   If yes, please list which one(s):

   ☐ Alcohol ☐ Drugs (please list) _____
   ☐ Tobacco ☐ Medications (please list)_____

3. Baby's Birth Weight _____ Weeks Gestation _____ Delivery: ☐ Vaginal ☐ C-Section

4. Were there any problems in the newborn period? ☐Yes ☐No

   If Yes, please describe:_____

DEVELOPMENTAL INFORMATION

1. At what age did the child walk _____ talk _____?
2. Has the child had any delays in ☐ Gross Motor (moving around) _____
   ☐ Fine Motor (controlling hands) _____
   ☐ Talking/Speech _____
   ☐ Social Interactions _____
3. Has the child received therapy ☐ Physical _____
   ☐ Speech _____
   ☐ Occupational _____
   ☐ ABA/Social _____
4. Does the child have any problems in school?
   ☐ Behavior _____
   ☐ Learning _____
   ☐ Bullying _____
   ☐ Social _____

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PREVIOUS HOSPITALIZATIONS (OVERNIGHT STAY) OR SURGERIES:

Age of Child	Hospital & City	Reason for Hospitalization/Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: ☐Yes ☐No

If Yes To What:	Symptom caused by allergy?
_____	_____
_____	_____
_____	_____

Are there any smokers in the home? ☐Yes ☐No

PAST MEDICAL HISTORY:

Does the child have any of the following medical problems:

Illness	Yes	No
Asthma or lung disease	☐	☐
Birth defect or genetic condition	☐	☐
Blood disorders (anemia, or bleeding disorders)	☐	☐
Cancers (including leukemia)	☐	☐
Cystic Fibrosis	☐	☐
Developmental delays	☐	☐
Diabetes	☐	☐
Eczema	☐	☐
Food Allergy or Hay fever	☐	☐
Frequent ear infections	☐	☐
Glaucoma or other eye problems	☐	☐
Hearing difficulty	☐	☐
Heart defect	☐	☐
Mental retardation	☐	☐
Muscle or joint disease /Broken bones	☐	☐
Seizure disorder	☐	☐
Tuberculosis	☐	☐
Thyroid or other gland disorder	☐	☐
Gastrointestinal Problems	☐	☐

ANY OTHER HEREDITARY or CHRONIC CONDITION?_____

MEDICATIONS: Please list any medications, vitamins, natural remedies or supplements taken on a daily or as-needed basis:

_____

_____