PEDIATRIC HEALTH HISTORY

New Patient, less than1 year old

HOSPITAL DRIVE PEDIATRICS

Patient Name:_____ Nickname:_____

Date of Birth:_____ Age_____

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

Prior Pediatrician: _____ City: _____

PREGNANCY/BIRTH INFORMATION:

1.Did child's mother receive prenatal care? ☐Yes ☐No

2.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:_____

3.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)_____

4.Was baby born within 2 weeks of the due date? ☐Yes ☐No

If No, how many weeks _____ ☐ early ☐ late.

5.Was the baby delivered "normally" (vaginal birth)? ☐Yes ☐No

If by C-section, what was the reason ? _____

6.What was the baby's birth weight?_____

7.Did the baby have any complications during the Newborn Nursery stay? ☐Yes ☐No

If Yes, please describe:

- ☐ Breathing problems _____
- ☐ Infection _____
- ☐ Jaundice requiring treatment _____
- ☐ Birth injury or defect _____
- ☐ Other _____

8.Were there any significant problems in the first two weeks after discharge from the Nursery? ☐Yes ☐No

If Yes, please describe:_____

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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 serious or long-term 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	☐	☐
Developmental Delays (physical, speech,etc)	☐	☐
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:

_____

_____