Willow Bend Pediatrics

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Date: ___/___/_____

Pediatric Medical History Form

NAME:_____ **DATE OF BIRTH:**_____/_____/_____

□ Male □ Female

Person completing form/relationship: _____

Birth History::

Mother's age at birth _____

Indicate any medical problems or other relevant issues during pregnancy:

List any medications taken by mother during pregnancy:

Delivered by: □ Vaginal delivery □ C-section If C-section list reason:_____

Number of weeks gestation or indicate full term _____

Birth weight _____ Birth length_____ APGAR scores 1min_____5min_____

Hepatitis B vaccine given □No □Yes If yes, date given_____

Please list any serious medical problems during the newborn period: □None

_____

_____

Medications:
□ None

Medication Allergies:
□ None known

Social History:
Parent's Marital Status:
□Married □Divorced □Single

Who else besides parents cares for the child regularly?

Name / Date of Birth of any siblings:

Safety/Environment:
Are there any smokers in the home?
□No □Yes

Are there any concerns about lead exposure? □No □Yes

Are there any problems with the condition of your home? □No □Yes

Family History: Indicate if present in any of your child's parents, siblings, grandparents, aunts/uncles, or first cousins

√	Diagnosis	Family Member	√	Diagnosis	Family Member
	ADD/ADHD			High cholesterol	
	Anemia/Bleeding disorder			Immune disorder	
	Asthma/Lung disorder			Intestinal or liver disease	
	Birth defect			Mental retardation	
	Cancer			Metabolic/Muscle disorder	
	Deafness/hearing loss			Neurologic disorder	
	Diabetes			Psychiatric disorder	
	Eczema/skin disease			Urinary tract/kidney disease	
	Genetic disease or syndrome			Seizures	
	Heart disease/stroke			Thyroid disease	
	High Blood Pressure			Tuberculosis	

For newborn patients may skip the remainder of the history form

Past Medical History:
List any major medical problems:
□None

List any hospitalizations other than for birth (include reason and dates):
□None

List any serious injuries in the past:
□None

To the best of my knowledge, my child is up to date on his/her immunizations: □Yes □No
If no, why? _____

Feeding & Nutrition:	Development:	**Dental History:**
History of colic or reflux? □Y□N Any unusual feeding/dietary problems? □Y□N	At what age did your child: Sit alone:_____ Walk alone:_____ Say words:_____	Has child been seen by a dentist? □Y□N Date of last visit:_____

Review of Systems: Please check any current problems your child has on the list below

General
___Fevers/chills/excessive sweating
___Unexplained weight loss/gain
Eyes
___Squinting/crossed eyes
___Asymmetric gaze
Ears/Nose/Throat
___Hard of hearing
___Mouth breathing/snoring
___Chronic runny nose/congestion/sore throat
___Problems with teeth/gums
Cardiovascular
___Tires easily with exertion
___Chest pain
___Fainting
___Palpitations
Respiratory
___Cough/wheeze
___Shortness of breath
Gastrointestinal
___Abdominal pain/nausea/vomiting/diarrhea
___Constipation
___Blood in bowel movement
___Feeding issues
Genitourinary
___Bedwetting
___Pain with urination/frequent urination
___Discharge: penile or vaginal
Musculosketetal
___Muscle/joint aches or pain
Skin
___Rashes
___Unusual moles
Neurological
___Headaches
___Weakness
___Clumsiness
Psychiatric/Emotional/Behavioral
___Speech problems
___Anxiety/stress
___Sleep issues
___Depression/suicidal thoughts
___Nail biting/thumb sucking
___Aggressive or concerning behavior patterns
Blood/Lymph
___Unexplained lumps
___Easy bruising/bleeding

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