Kids Care, Pc

PEDIATRIC HEALTH HISTORY

Patient Name_____ Date of Birth_____
Physician Name_____

Prenatal History
(Before Birth)

Significant Infections_____
Drug Use_____

Birth History

Birth Weight_____
Delivery (Check One): ____ Vaginal ____ Cesarean Section
Reason for Cesarean (If applicable):_____
Pregnancy(Check One): ___ Full Term ___ Pre-Term # of Weeks if Pre-Term:_____

Neonatal Problem
(Up to 6 weeks after Birth)

_____

Past Medical History

Hospitalization_____

Surgeries_____

Medications_____

Allergies_____

Developmental History

Sat without support- age in months _____

Walked without support-age in months _____

Toilet trained- age in months _____

First word spoken- age in months _____

Developmental Concerns

_____

Early Nutrition

Breastfed- duration in weeks_____ Bottle fed- duration in weeks_____

Formula type_____

Nutritional Concerns

_____

Type of Water in Household(Check One): ____ City ___ Well Other_____

Answer the questions below regarding members of the family/household

Number if members in Present Household:_____

Name: Relationship: Age:

_____

_____

_____

_____

_____

_____

_____

Family Medical History Including Child's Grandparents

Allergies_____

Anemia/ Bleeding_____

Congenital Defects_____

Cancer_____

Seizures_____

Migranine_____

Lung Disease/TB_____

Renal Disease_____

Gastro-intestinal Disease/ Live Disease_____

Endocrinological Problems (Thyroid, Pituitary)_____

Cardiovascular Disease HTN_____

Vision/Hearing_____

History of Substance Abuse_____

History of Developmental Delay_____

History of Psychiatric Disorder_____

Other Problems_____

_____

Physicians Signature_____