

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**BIRTH HISTORY**

**Please answer the following:**

Medications taken during pregnancy \_\_\_\_\_

If pregnancy complicated, please explain \_\_\_\_\_

Full Term  Yes  No Premature \_\_\_\_\_ weeks

Delivery  Vaginal \_\_\_\_\_  Cesarean Reason for C-section \_\_\_\_\_

Birth weight/length \_\_\_\_\_ / \_\_\_\_\_ Any problems in nursery (jaundice, cyanosis)?  Yes  No

If yes, please explain \_\_\_\_\_

**DEVELOPMENTAL & SOCIAL HISTORY**

**Please answer when your child met developmental milestones and describe issues with school behavior**

Roll over  On time  Late Grade in school \_\_\_\_\_

Sit up  On time  Late Marks in school \_\_\_\_\_

Walk alone  On time  Late Problems in school \_\_\_\_\_

Talk (2 words)  On time  Late

Toilet Train  On Time  Late

Diet problems \_\_\_\_\_

Sleep problems \_\_\_\_\_

Social problems \_\_\_\_\_

Behavioral problems \_\_\_\_\_

Personality \_\_\_\_\_

**MEDICAL HISTORY**

**Please fill in the following with dates and places with description**

Hospitalizations \_\_\_\_\_

Surgery \_\_\_\_\_

Allergies \_\_\_\_\_

Current medications \_\_\_\_\_

Past medications taken for more than 2 weeks \_\_\_\_\_

Immunizations \_\_\_\_\_

Have menstrual periods begun  No  Yes Age of onset \_\_\_\_\_ Cycles regular  No  Yes

Last menstrual period began \_\_\_\_\_ days ago Menstruation concerns \_\_\_\_\_

Any other health problems \_\_\_\_\_

**REVIEW OF SYSTEMS**

**Please check yes or no for the following symptoms your child may be experiencing**

		Y	N		Y	N		Y	N	Comments
<b>Constitutional</b>	Weight loss/gain			Fever			Fatigue			ROS 99242=1 99243=2-9 99244>=10 99245=>10
<b>Eyes</b>	Eye Swelling			Double vision						
<b>ENT</b>	Ear Infection			Throat pain			Nosebleeds			
<b>CV</b>	Chest Pain			Palpitations			Murmur			
<b>Resp</b>	Shortness of breath			Cough			Wheezing			
<b>GI</b>	Nausea/vomiting			Diarrhea			Abominal pain			
<b>GU</b>	Urinating Frequently			Allergy to meds			Urinary infection			
<b>Endocrine</b>	Urinating in large amts			Excessive thirst			Other			
<b>Skin</b>	Rash			Lesions						
<b>Musculoskeletal</b>	Joint swelling			Joint pain						
<b>Neuro</b>	Headache			Fainting						
<b>Psych</b>	Difficulty sleeping			Depression						
<b>Hem/Lymph</b>	Bruising/bleeding			Anemia			Swollen glands			
<b>Allergic/Immun</b>	Frequent infection			Allergy to meds						

Parent/Patient Signature: \_\_\_\_\_ Date completed: \_\_\_\_\_