

Swift Creek Pediatrics

Name: _____ MRN: _____

DOB: _____

Family History

	Date of Birth	Medical Problems
Mother		
Father		

Is there a family history of any of the following (include child's parents, siblings, grandparents, aunts and uncles)?

Please circle yes or no to all questions

Diabetes	Yes/No	Allergies	Yes/No
Asthma/Wheezing	Yes/No	Lazy Eye	Yes/No
Thyroid disease	Yes/No	Mental Problems	Yes/No
Emotional Problems	Yes/No	Bleeding tendencies	Yes/No
High Cholesterol	Yes/No	High Blood Pressure	Yes/No
Early Heart Attacks<50	Yes/No	Other Heart Disease	Yes/No
Hip Disorders in Infancy	Yes/No	Birth Defects	Yes/No
Tuberculosis	Yes/No	Epilepsy	Yes/No
Convulsions	Yes/No	Kidney Disease	Yes/No
Other Illnesses	Yes/No	School problems	Yes/No

If you answered yes to any of the above, please explain: _____

SOCIAL HISTORY

Marital status of parents: Married Single divorced

Has there been a separation, or death? Specify _____

What has been the attitude of your child to this situation? _____

Does anyone in your home smoke? Yes No

Is there a gun in your home? Yes No

With whom does the patient live? (List all household members and their relationship to patient.) _____

Prenatal History (To be completed if pregnant or child is less than 5 years of age)

Number of Pregnancies: _____ Obstetrician: _____

Number of Living Children: _____

Present Pregnancy

Due Date: _____ Complications _____

Did you take any drugs during pregnancy? Yes No

Did you smoke during pregnancy? Yes No

Did you drink any alcoholic beverages during pregnancy? Yes No

Has the child's mother had any miscarriages, still births, or abortions? Yes No

If yes to any above please explain _____

Birth History

Full term pregnancy _____ premature birth at _____ weeks
Adopted-at what age? _____
Has he/she been told he's adopted? Yes/No _____ Where was child born? _____
Vaginal / C-Section _____ Breast/Bottle _____ Birth weight _____ Length _____
Any problems at birth? Please specify _____

Child's Development

Please list age of child when the following milestones were reached
Sat alone at _____ mos. Walked at _____ mos. Words at _____ mos.
Sentences at _____ mos. First teeth at _____ mos.
Bladder trained at _____ mos. Bowel trained at _____ mos.
Does the child have any handicaps? Yes/No _____ Please specify _____
Is there a bed-wetting problem? Yes/NO _____
Is there a family history of bedwetting? Yes/No _____

PAST ILLNESSES

Please mark date or frequency of illness or specify substance causing allergy
Tonsillitis _____ Pneumonia _____
Asthma _____ Colds _____
Ear infections _____ Urinary infections _____
Allergic to medication _____ Seizures _____
Allergic to foods _____ Heart Murmur _____
Allergic to Insect Bites _____

Operations and Hospitalizations

Please specify date or reason
Appendectomy _____ Tonsils and Adenoids _____
Ear Tubes _____ Other Operation _____
Other hospitalizations _____

Medications

Is your child taking any medication on a regular basis? Yes/No _____
Please specify _____

School Performance

Scholastic performance: Academic _____
Behavior _____
Has child ever been in a special education class? Yes No
Has the child had a learning problem? Yes No
If yes, what type of learning problem? _____

Child's Previous Pediatrician

Name: _____ Phone#: _____

Anything else about your child?

Is there anything else about your child you feel we need to know to provide the best
medical care for him/her?
Please specify _____
Name of person completing this form _____

For office use only

The has been reviewed by _____, M.D. Date _____

