WELLSTAR Health System

Patient Name _____ M / F Date of Birth: _____

PEDIATRIC PATIENT HISTORY FORM

BIRTH HISTORY

Delivery: ___ Vaginal ___ Cesarean (C-) section - Due to:
_____
Were there any problems with this child's pregnancy or delivery? Y N
If yes, list:

Birth Weight:	**Length:**	**Head Circumference:**

Was this child premature? Y N If yes, how many weeks?

Did this child have any problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? Y N
If yes, please list:

Did this child need special treatment while in the hospital such as oxygen, transfusion, lights (phototherapy)?

Was (is) this child breast-fed? Y N for how many months?

Did (does) this child have any problems breast/formula feeding?

SOCIAL HISTORY (Circle the appropriate answers)

Parents: Married Divorced Separated Single other:
Patient lives with: Mom Dad step-mom/dad adoptive parent other:

Siblings - please list with ages (note if sibling lives elsewhere):

Is your child enrolled in daycare or school? No Yes- Please list:

Does your child participate in regular exercise? No Yes - Please list:

Does your child drink caffeine? Yes No amount:

Is there a swimming pool at home?	**No Yes**
Are guns kept in the home?	**No Yes**
Any pets at home? (If yes, please list type.)	**No Yes**
Any smokers at home?	**No Yes**
Are there smoke detectors at home?	**No Yes**
Are there carbon monoxide detectors at home?	**No Yes**
Does the patient use seat belts/car safety seats?	**No Yes**
Does the patient use a safety helmet for riding a bike, scooter, skateboard and roller skates/blades?	**No Yes**

What kind of water does the child drink?
City/county water well water bottled water bottled water *with* fluoride

Any issues/stresses for the family that we should be aware of? ? No Yes
please list:

Provider of information initials/date _____ _____MD/PNP

MEDICAL HISTORY		
Hospitalizations: None Yes - list:		
Surgeries? None Yes - list:		
Other chronic or serious medical problems? None Yes - list:		
Has your child seen a specialist or sub-specialist for any medical or mental health problems? No Yes - list:		
Has your child had chicken pox disease/ vaccine? No Yes - date of disease:		
Did you bring a copy of your child's immunization record"? Yes No **If no, please provide as soon as possible.** **Is he/she behind on vaccinations? Yes No if yes, needs:**		
REVIEW OF SYSTEMS		
Has your child had any problems with...		
Lung/breathing/ coughing?	**None**	**Yes - list:**
Heart?	**None**	**Yes - list:**
Kidney/urinary tract/bladder?	**None**	**Yes - list:**
Bone/muscle/joints?	**None**	**Yes - list:**
Stomach/digestive/ gastrointestinal system?	**None**	**Yes - list:**
Brain/nervous system?	**None**	**Yes - list:**
Genital or breast?	**None**	**Yes - list:**
Skin?	**None**	**Yes - list:**
Eye/ear/nose/throat/ sinus/hearing/ vision?	**None**	**Yes - list:**
Development or learning?	**None**	**Yes - list:**
Behavioral problems or eating?	**None**	**Yes - list:**
Does your child take any medications (including prescription, over-the-counter, vitamins, birth control pills, herbal remedies)? Please list dose and frequency:		
Is the child allergic to or have a reaction to any medication? No Yes (please list along with reaction**)**		
Are there any other medical or social issues of which we should be aware?		

FAMILY MEDICAL HISTORY						
	Child's father	**Child's mother**	**Sibling**	**Sibling**	**Grand-parent**	**Other relative**
Anemia						
Asthma/Reactive Airway Disease						
Cancer (list type)						
Congenital birth defects						
Cystic Fibrosis						
High cholesterol						
Diabetes (note childhood or adult onset)						
Drug abuse/alcohol abuse						
Eating disorder/obesity						
Hypertension (high blood pressure)						
Heart disease/heart attack before age 55? List person's risk factors (i.e. high blood pressure, smoking, high cholesterol, etc.)						
Kidney disease						
Migraine headaches						
Psychiatric or mental health problems						
Seizures or epilepsy						
Stroke						
Death (list cause if known)						
Other:						

COMMUNICATION NEEDS

Primary language if other than English: **Child** **Parent(s)**

Any special communication needs? **No** **Yes - list:**

PATIENT EDUCATION ASSESSMENT

Would you prefer patient education be provided to you or your child by:

Demonstration **Other - list:**

Written Materials

PATIENT RIGHTS

Is there anything we need to know about your religion or culture in order to care for your child?

No **Yes - list:**

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