ALL ABOUT KIDS PEDIATRICS

****Heath history is extremely important to us. Please take the time to fully and completely answer the following questions on behalf of your child****

PAST MEDICAL HISTORY

*****Explain any "YES" answers below in EXPLANATIONS*****

For your child:

Allergic to any medications? **Y / N**
Frequent Ear Infections? **Y / N**
History of seasonal allergies? **Y / N**
History of wheezing, use of Albuterol or a Nebulizer? **Y / N**
Heart Murmur? **Y / N**
Any Chronic Diseases? **Y / N**
History of Constipation? **Y / N**
History of Urinary Tract Infections? **Y / N**
History of Bedwetting after age 4 ? **Y/ N**
History of Headaches? **Y / N**
History of Sleeping Problems/Snoring? **Y / N**
History of ADD/ADHD? **Y / N**
Any previous injuries? **Y / N**
Any ER or Urgent Care visits? **Y / N**
Any previous surgeries or hospitalizations? **Y / N**

SOCIAL HISTORY

Pt resides with: Both Parents, Mom, Dad, Other
Are there any Step Parents Involved? **Y / N**
Who lives at home? _____
Pt has how many siblings? _____
Does your child attend DayCare? **Y / N**
Passive smoke exposure? **Y / N**
Seat belt/car seat used routinely? **Y / N**
Sunscreen used routinely? **Y / N**
Guns present in the home? **Y / N**
Pool at residence? **Y / N** Locked/Gated **Y/ N**

DEVELOPMENTAL HISTORY

Walked alone at what age? _____
First word at what age? _____
Any speech delays? **Y / N**
Other delays or concerns? **Y / N** _____

FAMILY HISTORY *(Include ALL illnesses)*

(Ex: Diabetes, High Blood Pressure, Heart Disease, Asthma, etc.)

Your Child's . . .
Biological Mother _____
Biological Father _____
Maternal Grandmother _____
Maternal Grandfather _____
Paternal Grandmother _____
Paternal Grandfather _____
Maternal Aunt(s) _____
Maternal Uncle(s) _____
Paternal Aunt(s) _____
Paternal Uncle(s) _____
Sister(s) _____
Brother(s) _____
Cousin(s) _____
Other(s) _____

BIRTH HISTORY

Type of Delivery: **Vaginal or C-Section** Child# _____
Full Term? **Y / N** PreTerm? **Y / N** **If "yes"** _____**wk**
NICU Admit? **Y / N**
Jaundice? **Y / N** ***If "yes" phototherapy? Y / N**
Any Birth Defects? **Y / N** _____
Birth Weight _____**lbs** _____**oz**
Birth Length _____**inches**
Passed hearing test? **Y / N**
Breech? **Y / N**
Any problems while in the nursery? **Y / N** ***If "yes" please explain.** _____

EXPLANATIONS: _____

REVIEW OF SYSTEMS

****Please circle if any of the following apply to your child****

Constitutional: *Excess weight gain *Excess weight loss *Loss of appetite *Fever *Fussy *Diminished activity *Fatigue
Eyes: *Eye pain *blurry vision *Eye redness *Eye itchiness *Eye swelling *Eye discharge
ENMT: *Ear pain or discharge *Hearing loss *Sinus pressure *Drooling *Congestion *Sore throat *Hoarseness *Foul breath
Breasts: *Lumps *Tenderness *Discharge
Cardiovascular: *Chest pain *Rapid heart beat
Respiratory: *Cough *Wheezing *Chest tightness *Pain with respiration *Noisy breathing *Rapid respirations *Difficulty breathing
GI: *Difficulty swallowing *Abdominal pain *Nausea *Vomiting *Diarrhea *Constipation *Blood in stools *Mucus in stool
GU General: *Discharge *Blood in urine *Increased frequency *Urgency
Endocrine: *Increased thirst *Increased drinking *Temperature Instability
Skin: *Pain *Itchiness *Dry skin *Flaking *Redness *Rash *Diaper rash *Hives *Skin lesions *Bruising *Insect bites
Musculosketal: *Swelling *Joint swelling *Limited motion *Previous injuries *Trauma
Neuro: *Numbness *Weakness *Tingling *Burning *Shooting pain *Headache *Dizziness *Loss of consciousness
Psych: *Depression *Anxiety *Insomnia *Stress *Loss of interest
Allergy/Immunologic: *Sneezing *Runny nose