

# FAMILY MEDICINE OF PORT ANGELES

## PEDIATRIC HISTORY FORM

CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE FORM FILLED OUT: \_\_\_\_\_

### A. BIRTH HISTORY

1. Birthplace \_\_\_\_\_
2. Birthdate \_\_\_\_\_
3. Was pregnancy normal? \_\_\_\_\_
4. Was delivery normal? \_\_\_\_\_
5. Was baby full term? \_\_\_\_\_
6. Birth weight \_\_\_\_\_
7. Birth length \_\_\_\_\_
8. Any nursery problems? \_\_\_\_\_

### B. GROWTH AND DEVELOPMENT

1. Ages when first:  
Sat \_\_\_\_\_ Crawled \_\_\_\_\_  
Rolled \_\_\_\_\_ Walked \_\_\_\_\_  
First Teeth \_\_\_\_\_ Toilet Trained \_\_\_\_\_
2. School History:  
Year in school \_\_\_\_\_ Nursery \_\_\_\_\_  
Grades averaged \_\_\_\_\_  
School name \_\_\_\_\_  
Attends special school or classes? \_\_\_\_\_  
Discipline or behavior problem? \_\_\_\_\_  
Ever seen by Psychologist, Speech Therapist or Special Teachers? \_\_\_\_\_

### C. PAST MEDICAL HISTORY

1. Any problems with:  
Sleeping? \_\_\_\_\_ Bedwetting? \_\_\_\_\_  
Weight/Height? \_\_\_\_\_ Nail Biting? \_\_\_\_\_  
Nightmares? \_\_\_\_\_
2. Diet  
Nursed or Bottle Fed? \_\_\_\_\_  
Any Colic problems? \_\_\_\_\_  
Use special diets? \_\_\_\_\_  
Taking Vitamins? \_\_\_\_\_  
Taking Fluoride? \_\_\_\_\_
3. Contagious Diseases (What age?)  
Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_  
Mumps \_\_\_\_\_ Rubella (German Measles) \_\_\_\_\_  
Scarlet Fever \_\_\_\_\_ Any other? \_\_\_\_\_
4. Immunizations (Shots) – Please give ages and/or dates.  
DPT series \_\_\_\_\_ Boosters \_\_\_\_\_  
Polio series \_\_\_\_\_ Boosters \_\_\_\_\_  
Smallpox \_\_\_\_\_ Boosters \_\_\_\_\_  
Measles \_\_\_\_\_  
Rubella (German Measles) \_\_\_\_\_  
Mumps \_\_\_\_\_  
TB (Tine) Test \_\_\_\_\_  
Others \_\_\_\_\_
5. Medications (Does your child take any now?) \_\_\_\_\_

### D. HOSPITALIZATIONS

(When, Where, Why?) \_\_\_\_\_  
\_\_\_\_\_

### E. SURGERY

(When, Where, Why?) \_\_\_\_\_  
\_\_\_\_\_

### F. SERIOUS INJURIES

(When, Where?) \_\_\_\_\_  
\_\_\_\_\_

### G. ALLERGIC REACTIONS

(Drugs, Asthma, Hives, Eczema, Hay Fever) \_\_\_\_\_  
\_\_\_\_\_

### H. FAMILY HISTORY

1. Father: Living? \_\_\_\_\_ Age now \_\_\_\_\_ Health \_\_\_\_\_
2. Mother: Living? \_\_\_\_\_ Age now \_\_\_\_\_ Health \_\_\_\_\_
3. Brother/Sisters? \_\_\_\_\_ How Many? \_\_\_\_\_  
Ages \_\_\_\_\_ Healthy? \_\_\_\_\_
4. Any Family History of:  
Diabetes \_\_\_\_\_ Allergies \_\_\_\_\_ Convulsions \_\_\_\_\_  
Heart Disease \_\_\_\_\_ TB \_\_\_\_\_ Cancer \_\_\_\_\_  
Other? \_\_\_\_\_

### I. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA?

WHERE DID YOU LIVE BEFORE COMING TO THIS AREA?  
\_\_\_\_\_

### J. GENERAL SURVEY

Has your child had any unusual problems with the following?  
Head \_\_\_\_\_  
Eyes \_\_\_\_\_  
Ears/Nose/Throat \_\_\_\_\_  
Chest/Heart/Lungs \_\_\_\_\_  
Stomach \_\_\_\_\_  
Kidneys \_\_\_\_\_  
Bladder \_\_\_\_\_  
Bones, Muscles, Joints \_\_\_\_\_  
Skin \_\_\_\_\_  
Blood \_\_\_\_\_  
When was your child's last blood test? \_\_\_\_\_  
When was your child's last urine test? \_\_\_\_\_

### K. ANY SPECIAL COMMENTS ABOUT YOUR CHILD?

\_\_\_\_\_  
\_\_\_\_\_

### L. YOUR LAST DOCTOR WAS:

\_\_\_\_\_  
\_\_\_\_\_