

Name _____

Pediatric Associates, LLP

Date _____

D.O.B. _____

CHILD HISTORY RECORD

To be filled out by parent or guardian.

Pregnancy & Birth

1. Birth Weight _____ Birth Length _____
2. Age of Mother @ baby's birth _____
3. Infant's gestational age Full-term Preterm If so, # of weeks _____ Post-term
4. Blood Type of Mother _____ Blood Type of Infant (if known) _____
5. Apgar Scores (if known) _____
6. Type of Delivery Vaginal C-section If so, reason _____ Group B Strep Status of Mother _____
7. Initial feeding of baby Breast Bottle
8. Name of obstetrician / City / State _____
9. Did mother use cigarettes, alcohol, recreational drugs, or medications during this pregnancy? Yes No
If yes, explain _____

10. Were there any medical problems during the pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor)? Yes No
If yes, explain _____

11. Were there any problems during labor? Yes No
If yes, explain _____

12. Were there any problems during the nursery stay (i.e., jaundice, prematurity, feeding difficulties, breathing problems, or infections)? Yes No
If yes, explain _____

Hospitalizations or Serious / Unusual Illnesses

Identify any serious and/or unusual illnesses which your child has experienced and the corresponding date(s).

Date	Serious/Unusual Illness	Hospital/Physician's Name	City, State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

List allergies, including any allergic reactions to drugs.

Family History

Illnesses – Check (✓) where the child or members of the child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems.

	Child	Child's Family		Child	Child's Family
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Kidney / bladder problems or infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds / sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Croup	<input type="checkbox"/>	<input type="checkbox"/>	Early heart disease (age 50 or less)	<input type="checkbox"/>	<input type="checkbox"/>
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing / asthma	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease / tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol / drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Emotional disorders / suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Eczema / skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained childhood deaths	<input type="checkbox"/>	<input type="checkbox"/>
Anemia / blood problems	<input type="checkbox"/>	<input type="checkbox"/>	Other illnesses	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

General Health

	First Name	Year of Birth	Sex	Health Good	Health Problems (Explain)
Mother	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> _____
Father	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> _____
Brothers	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> _____
	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> _____
& Sisters	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> _____
	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> _____
	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> _____

Have any of the child's brothers or sisters died? No Yes (explain) _____

Family History

Health and Safety Issues

	Yes	No
1. Are there any guns in the child's house?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child use a toothbrush daily?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the child use a car seat or seat belt all the time?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are there smoke detectors in the child's home?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the hot water temperature less than 125°?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have rules/limits for television viewing?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are medicines and potential poisons out of reach?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have syrup of ipecac?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you know child resuscitation or choking management?	<input type="checkbox"/>	<input type="checkbox"/>