Name _____ Date _____

D.O.B. _____

Pediatric Associates, LLP

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 _____

	Yes	No
9. Did mother use cigarettes, alcohol, recreational drugs, or medications during this pregnancy?	☐	☐
If yes, explain _____		
10. Were there any medical problems during the preganancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor)?	☐	☐
If yes, explain _____		
11. Were there any problems during labor? _____	☐	☐
If yes, explain _____		
12. Were there any problems during the nursery stay (i.e., jaundice, prematurity, feeding difficulties, breathing problems, or infections)?	☐	☐
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	☐	☐	Kidney / bladder problems or infections	☐	☐
Frequent colds / sore throats	☐	☐	Seizures / convulsions	☐	☐
Croup	☐	☐	Early heart disease (age 50 or less)	☐	☐
Cystic fibrosis	☐	☐	High blood pressure	☐	☐
Wheezing / asthma	☐	☐	High cholesterol	☐	☐
Pneumonia	☐	☐	Lung disease / tuberculosis	☐	☐
Eye problems	☐	☐	Sexually transmitted diseases	☐	☐
Dental problems	☐	☐	Alcohol / drug abuse	☐	☐
Hearing problems	☐	☐	Emotional disorders / suicide attempts	☐	☐
Hay fever	☐	☐	Cancer	☐	☐
Eczema / skin problems	☐	☐	Unexplained childhood deaths	☐	☐
Anemia / blood problems	☐	☐	Other illnesses	☐	☐
Diabetes	☐	☐	_____		

General Health

	First Name	Year of Birth	Sex	Health Good	Health Problems	(Explain)
Mother	_____	_____	_____	☐	☐	_____
Father	_____	_____	_____	☐	☐	_____
Brothers & Sisters	_____	_____	_____	☐	☐	_____
	_____	_____	_____	☐	☐	_____
	_____	_____	_____	☐	☐	_____
	_____	_____	_____	☐	☐	_____
	_____	_____	_____	☐	☐	_____

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?	☐	☐
2. Does the child use a toothbrush daily?	☐	☐
3. Does the child use a car seat or seat belt all the time?	☐	☐
4. Are there smoke detectors in the child's home?	☐	☐
5. Is the hot water temperature less than 125°?	☐	☐
6. Do you have rules/limits for television viewing?	☐	☐
7. Are medicines and potential poisons out of reach?	☐	☐
8. Do you have syrup of ipecac?	☐	☐
9. Do you know child resuscitation or choking management?	☐	☐