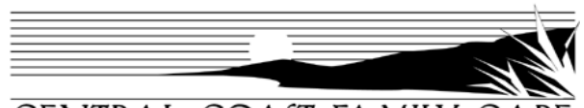


PEDIATRIC HISTORY FORM



CENTRAL COAST FAMILY CARE

MEDICAL ASSOCIATES OF SANTA MARIA, INC.

Childs Name _____ Age _____ Today's date _____

Birthdate _____

BIRTH HISTORY: BIRTHPLACE _____

WAS PREGNANCY NORMAL? _____

WAS DELIVERY NORMAL? _____

WAS BABY FULL-TERM? _____

BIRTH WEIGHT: _____ LENGTH _____

ANY NURSERY PROBLEMS? _____

GROWTH & DEVELOPMENT

AGES WHEN FIRST:

SAT _____ CRAWLED _____

ROLLED _____ WALKED _____

FIRST TEETH _____ TOILET TRAINED _____

SCHOOL HISTORY:

YEAR IN SCHOOL _____ NURSERY _____

GRADES AVERAGED _____

SCHOOL NAME: _____

SCHOOL PROBLEMS: _____

ATTENDS SPECIAL SCHOOL OR CLASSES: _____

DISCIPLINE OR BEHAVIOR PROBLEMS: _____

EVER SEEN BY PSYCHOLOGIST, SPEECH THERAPIST, OR SPECIAL TEACHERS: _____

PAST MEDICAL HISTORY:

SLEEPING? _____ BEDWETTING? _____

WT/HT? _____ NAIL BITING? _____

NIGHTMARES? _____

DIET: _____

NURSE OR BOTTLE FED? _____

ANY COLIC PROBLEMS? _____

USE SPECIAL DIETS? _____

TAKING VITAMINS? _____

TAKING FLUORIDE? _____

CONTAGIOUS DISEASES (WHAT AGE?)

MEASLES: _____ MUMPS _____

RUBELLA (GERMAN MEASLES) _____

CHICKENPOX _____ SCARLET FEVER: _____

ANY OTHER? _____

IMMUNIZATIONS (SHOTS): PLEASE GIVE AGE OR DATES

DPT SERIES _____ BOOSTERS: _____

POLIO SERIES _____ BOOSTERS: _____

SMALLPOX _____ BOOSTERS: _____

MEASLES _____ MUMPS _____

RUBELLA (GERMAIN MEASLES) _____

TB (TINE) TEST _____ HIB _____

OTHERS? _____

MEDICATIONS: DOES YOUR CHILD TAKE ANY NOW?

IF SO, PLEASE LIST: WHEN, WHERE, WHY?

SURGERY: WHEN, WHERE, WHY?

SERIOUS INJURIES: WHEN, WHERE?

ALLERGIC REACTIONS: DRUGS, ASTHMA, HIVES, ECZEMA, HAYFEVER?

FAMILY HISTORY:

FATHER LIVING? _____ AGE NOW? _____ HEALTH _____

MOTHER LIVING? _____ AGE NOW? _____ HEALTH _____

BROTHERS/SISTERS _____ HOW MANY? _____

AGES _____

HEALTH _____

ANY FAMILY HISTORY OF:

DIABETES: _____ ALLERGIES: _____

CONVULSIONS: _____ HEART DISEASE: _____

CANCER: _____ OTHER: _____

HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA? _____

WHERE DID YOU LIVE BEFORE COMING HERE? _____

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 CHILDED LAST URINE TEST: _____

ANY SPECIAL COMMENTS ABOUT YOUR CHILD? _____

YOUR CHILD'S LAST DOCTOR WAS: _____

ADDRESS: _____