PEDIATRIC HISTORY FORM

_____

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?_____

CENTRAL COAST FAMILY CARE

MEDICAL ASSOCIATES OF SANTA MARIA, INC.

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: _____