BUCKEYE FAMILY HEALTH
Internal Medicine & Pediatrics

NEW PATIENT HISTORY, PEDIATRIC

Ages 0 – 6 years
TO BE FILLED OUT BY PARENT

Mother's name_____Age____

Occupation_____

Father's name_____Age____

Occupation_____

PATIENT NAME_____

BIRTH DATE_____

If adults in the household work outside the home, what child care arrangements are made for this child?

A. PREGNANCY AND BIRTH:

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins and iron? No Yes
4. Was the baby on time? No Yes
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No Yes
   What kind?_____
   _____

B. PAST MEDICAL HISTORY:

1. Where has you child gone for check-ups until now?
   ____
2. Date of last check-up: _____
3. Date of last dental check-up: _____
4. Has you child had allergic reactions to any medications, foods, insect bites? No Yes
   Which ones?_____
5. 5. Has you child had reactions to any immunizations? No Yes
   Which ones?_____
6. Any hospitalizations other than for birth? No Yes
   For what?_____
7. Any serious injuries? No Yes
   What kind?_____
8. Are any medications taken regularly? No Yes
   Which ones?_____

C. FAMILY HISTORY:

1. Are the child's parents both in good health? No Yes
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts or uncles have had: anemia, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, or other.
3. List age, sex and general health of brothers and sisters_
   _____
   _____
4. Have any of your children died? No Yes

D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? No Yes
2. Is it good now? No Yes
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months is he/she (was he/she) breast fed or bottle fed?_____
6. If still on formula, which one do you use?_____
7. Does he/she take vitamins? No Yes

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throats? No Yes
5. Is there asthma, pneumonia or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Please list any other medical problems:_____
    _____
    _____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1½ years old? No Yes
4. How does this child compare to others his or her age?_
   _____
5. Does he/she have any trouble sleeping? No Yes
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? No Yes
8. Does he/she get along with other children? No Yes
9. Circle if you child has had any of the following:
   Nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others

G. SAFETY / ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other? (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? No Yes
3. Is there a working smoke alarm on each floor in the house? No Yes
4. Does your child always use a car seat / seat belt when riding in a car? No Yes
5. Are there any smokers in the household? No Yes
6. Are there any problems with the condition of your home? (peeling paint, insects, rats or mice) No Yes
7. Does your child always wear a helmet when riding his/her bicycle? No Yes

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS?

No / Yes