Alice Pediatric Clinic
Children's Healthcare

Patient Name:_____

DOB:_____

Date:_____

Allergies: (Include Drug, Reaction, and Age of Onset):

_____

_____

Current Problems:

_____

_____

History:

Birth History:

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____
Discharge Weight: _____ Gestational Age at Birth (weeks): _____ Delivery Method: Vaginal C-Section
Duration of Labor: If C-Section why?_____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____
Infant Feeding : Breast Bottle Both Formula Name? _____

Comments: Newborn Hearing Screening: Pass Fail , Other Comments: _____
_____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD_____	Yes	No	Allergic Rhinitis _____	Yes	No
Anemia _____	Yes	No	Asthma _____	Yes	No
Congenital Heart Disease_____	Yes	No	Constipation _____	Yes	No
Developmental delay _____	Yes	No	Diabetes _____	Yes	No
Eczema _____	Yes	No	Food Allergies _____	Yes	No
GE Reflux _____	Yes	No	Mental Illness _____	Yes	No
Murmur _____	Yes	No	Prematurity _____	Yes	No
Recurrent Otitis (ear infections) ___	Yes	No	Recurrent Strep Throat _____	Yes	No
Seizures _____	Yes	No	Substance Abuse _____	Yes	No
UTI _____	Yes	No	Vision Problems _____	Yes	No
Vesicoureteral Reflux _____	Yes	No	Wheezing _____	Yes	No

Other Medical History:

_____

_____

Surgical History: (Check Appropriate Box)

			Date	Surgeon
Adenoidectomy (adenoids removal)	Yes	No		
Appendectomy (appendix removal)	Yes	No		
Ear Tubes _____	Yes	No		
Fundoplication _____	Yes	No		
Gastrostomy Tube Placement ____	Yes	No		
Heart Surgery_____	Yes	No		
Hernia Repair_____	Yes	No		
Orthopedic Surgery _____	Yes	No		
Tonsillectomy _____	Yes	No		
Urologic Surgery _____	Yes	No		
VP Shunt_____	Yes	No		

Other Surgical History:

_____

_____

Alice Pediatric Clinic
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Patient Name:_____

DOB:_____

Date:_____

Family History: (Check all boxes that apply)

Relationship to CHILD		Name	A:Alive	D:Deceased	ADD/ADHD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		A	D																		
	Father		A	D																		
Sibs	Sister		A	D																		
	Brother		A	D																		
Aunts/ Uncles	*M Aunt		A	D																		
	*M Uncle		A	D																		
	*P Aunt		A	D																		
	*P Uncle		A	D																		
Grand-parents	*MGM		A	D																		
	*MGF		A	D																		
	*PGM		A	D																		
	*PGF		A	D																		

Comments (including other family medical problems):_____

*M=Maternal, the patient's mother's side of the family *P=Paternal, the patient's father's side of the family

Additional Family History, including other siblings, may be added below:

Relationship to CHILD	Name																				
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		

Home Environment:

Number of People at Home: _____
Lives with biological parents: Yes No
Foster Care: Yes No
Primary Care Givers (circle): Parents Daycare Relatives Others:_____
Daycare (hours/day): _____
Time at Relatives (hours/day): _____
Pets: Yes No

Parent's Status:

Parent's Marital Status (circle): Married Divorced Single Other_____

Mother's Occupation: _____
Father's Occupation: _____