# PEDIATRIC MEDICINE, P.A.

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## HISTORY SHEET

Name: _____Birth Date: _____Gender: _____
Referred By: _____

**CURRENT PROBLEMS/CONCERNS:**

_____
_____
_____
_____

**PAST HISTORY:**
Hospitalizations/Surgery, date and diagnosis: _____
_____
Current medications: _____
Allergies to medication: _____
Check if child has had:

- ❑ Chicken Pox
- ❑ Measles
- ❑ Recurrent tonsillitis
- ❑ Ear Infections
- ❑ Asthma
- ❑ Hepatitis
- ❑ Urine Infection
- ❑ Pneumonia
- ❑ School problems
- ❑ Allergies to foods
- ❑ Febrile Seizure
- ❑ RSV

**BIRTH HISTORY:**
Birth weight: _____ Feeding: Breast _____ Bottle_____
Problems as a newborn: _____
_____
Problems in pregnancy or delivery: _____
_____
Smoking during pregnancy? ❑ Yes ❑ No

Alcohol during pregnancy? ❑ Yes ❑ No

Medications during pregnancy? _____
_____
**GROWTH and DEVELOPMENT:**
Age at which sat: _____Walked alone: _____ Spoke single word: _____ Spoke in sentences: _____
School grade: _____ Regular class _____Special _____
Problems/Concerns _____
_____
_____

Does anyone smoke in the home? ❑ Yes ❑ No
Does child attend daycare? ❑ Yes ❑ No

Languages spoken in the home: _____

**FAMILY HISTORY:**

Mother's age: _____ Health problems: _____
Father's age: _____ Health problems: _____
Sibling's age: _____ Gender: _____ Problems: _____
_____ Gender: _____ Problems: _____
_____ Gender: _____ Problems: _____
_____ Gender: _____ Problems: _____
_____ Gender: _____ Problems: _____

Are these both the biologic (natural) parents? ❑ Yes ❑ No
If no, please explain: _____
_____
_____

Have any siblings died? ❑ Yes ❑ No

If yes, cause: _____ Age at death: _____ Date of death: _____

Please check if any of the following diseases have occurred in close family members. If checked, please indicate which family member and brief explanation:

- ❑ Heart attacks/disease in those less than 45 years _____
- ❑ Diabetes _____
- ❑ Cancer _____
- ❑ Epilepsy _____
- ❑ Asthma/allergies _____
- ❑ Kidney disease _____
- ❑ Cystic fibrosis _____
- ❑ Muscular dystrophy _____
- ❑ Blood disorders _____
- ❑ Deafness _____
- ❑ Mental retardation _____
- ❑ Depression/other psychiatric problems _____
- ❑ Hepatitis _____
- ❑ H.I.V. _____
- ❑ A.D.H.D./A.D.D. _____
- ❑ Other _____
- ❑ Additional information _____

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