DAVENPORT PEDIATRICS

INITIAL PEDIATRIC HISTORY FORM

Last Name	First Name	MI	Date of Birth (Month, Date, Year)

Mother/ Guardian	**How many brothers/ sisters?**
Father/ Guardian	**Who does the patient live with?**
Primary Care Physician/ Pediatrician	**Other doctors involved with patient's care?**

A. BIRTH HISTORY

Birthplace: _____ Birth weight: _____ Birth Length: _____

Was the pregnancy normal? □ No □ Yes □ Other _____ Was the delivery normal? □ No □ Yes □ Other _____

Was the baby full term? □ No □ Yes □ Other _____ Any nursing problems? □ No □ Yes □ Other _____

B. GROWTH AND DEVELOPMENT

At what age did the child:

first sat-up □ Precocious □ Average □ Other_____ first crawled □ Precocious □ Average □ Other_____

first rolled □ Precocious □ Average □ Other_____ first walked □ Precocious □ Average □ Other_____

first talked □ Precocious □ Average □ Other_____ toilet trained □ Precocious □ Average □ Other_____

School History: Current School Grade: _____ School Name: _____

Academic Performance: □ Not in School □ Remedial/ Special Ed □ Below Average □ Average □ Above Average

School Problems: _____ Attends special school or classes: _____

Discipline or behavior problems: _____

Ever seen by a psychologist, speech therapist, or special teachers: _____

C. PAST MEDICAL HISTORY

Any problems with: Sleeping: □ No □ Yes □ Other _____ Bedwetting: □ No □ Yes □ Other _____

Weight/Height: □ No □ Yes □ Other _____ Nail Biting: □ No □ Yes □ Other _____

Nightmares: □ No □ Yes □ Other _____

Diet: Nursed: □ No □ Yes □ Other _____ Bottled fed: □ No □ Yes □ Other _____

Colic problems: □ No □ Yes □ Other _____ Special diets □ No □ Yes □ Other _____

Contagious Diseases: (At what age) Chicken Pox: _____ Scarlet Fever: _____ Any Other: _____

Was your child ever diagnosed with any of the following? (At what age)

Seizures: □ No □ Yes □ Age _____ Asthma: □ No □ Yes □ Age _____

Bronchitis: □ No □ Yes □ Age _____ Pneumonia: □ No □ Yes □ Age _____

Ear Infections: □ No □ Yes □ Age _____ Any Other: _____

Please explain any YES answer in detailed description in the box provided.

Has the patient ever had any surgery or been hospitalized?	**□ No □ Yes**	**Surgeries/ Serious Injuries (Where, Why)**	**Dates**	**Hospitalizations other than surgery (Where, Why)**	**Dates**
Has the patient had any problems with anesthesia?					
Is the patient currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	**□ No □ Yes**	**Medication**	**Dosage**	**Medication**	**Dosage**
Does the patient have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	**□ No □ Yes**				

FAMILY HISTORY: Please indicate if parents, brothers, and/ or sisters have had any of the following conditions:

Condition	Relation to Patient	Condition	Relation to Patient
Cancer □ No □ Yes □ Other_____		Kidney Problems □ No □ Yes □ Other_____	
Diabetes □ No □ Yes □ Other_____		Allergies □ No □ Yes □ Other_____	
Heart Disease □ No □ Yes □ Other_____		TB □ No □ Yes □ Other_____	
Convulsions □ No □ Yes □ Other_____		Other_____	

GENERAL INFORMATION: Has your child had any unusual problems with the following?

Head: □ No □ Yes □ Other _____ Stomach: □ No □ Yes □ Other _____

Eyes: □ No □ Yes □ Other _____ Kidneys: □ No □ Yes □ Other _____

Ears/ Nose/ Throat: □ No □ Yes □ Other _____ Bladder: □ No □ Yes □ Other _____

Chest/ Heart/ Lungs: □ No □ Yes □ Other _____ Skin: □ No □ Yes □ Other _____

Bones/ Muscles/ Joints: □ No □ Yes □ Other _____ Blood: □ No □ Yes □ Other _____

D. IMMUNIZATIONS: Did you bring a record of immunizations of your child? □ No □ Yes □ Other _____

E. Any special comments about your child? _____

_____ _____ _____

Person Completing This Form/ Relationship to Patient **Reviewed by Provider** **Date**