Cross Creek PEDIATRICS

Initial Pediatric History

Chart # _____

Name of Patient _____ DOB _____/_____/_____ Sex: ☐ F ☐ M

Form Completed by _____ Relationship to Patient _____ Date_____/_____/_____

FAMILY

Are mother and father ☐ married ☐ separated / divorced ☐ other?

If separated / divorced, what is the patient's custody status?

_____

If one or both parents are not living in the home, how often does the child see that parent(s)? _____

Are there siblings living away from home? ☐ Yes ☐ No

If yes, give name, age & where they live.

_____ _____

_____ _____

_____ _____

Name	Relation	DOB	Health Probs

List all family members living in the patient's home

CURRENT MEDICAL HISTORY

Are immunizations up to date? ☐ Yes ☐ No

Is your child having any medical problems? Yes ☐ No ☐ If yes, _____

Do you consider your child to be in good health? Yes ☐ No ☐

Current Medications: _____

Drug Allergies? Yes ☐ No ☐

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

Does patient have or has ever had any of the following:

		Yes	No	Explain
1.	A serious medical problem?	☐	☐	_____
2.	Been hospitalized or had surgery?	☐	☐	_____
3.	Had a serious injury or accident?	☐	☐	_____
4.	Chickpox? When? _____	☐	☐	_____
5.	Allergies,asthma, bronchitis, respiratory infections?	☐	☐	_____
6.	Repeated ear infections, tubes, difficulty with hearing?	☐	☐	_____
7.	Problems with eyes or vision?	☐	☐	_____
8.	Heart problems or a heart murmur?	☐	☐	_____
9.	Anemia, bleeding problems or blood transfusion?	☐	☐	_____
10.	Abdominal pain, constipation requiring doctor visit?	☐	☐	_____
11.	Recurrent vomiting and/or diarrhea, blood in stool?	☐	☐	_____
12.	Bladder or kidney infections, bed-wetting after 5 yrs?	☐	☐	_____
13.	Recurrent skin problems (acne, eczema, etc)?	☐	☐	_____
14.	Headaches, convulsions, other neurologic problems?	☐	☐	_____
15.	Diabetes, thyroid or other endocrine problems?	☐	☐	_____
16.	If female, has she started her menstrual periods?	☐	☐	_____
	If yes, is she having any problems?	☐	☐	_____

DEVELOPMENT

Are you concerned about the patient's…	Yes	No	Explain
1. Physical development?	☐	☐	_____
2. Mental or emotional development?	☐	☐	_____
3. Learning ability?	☐	☐	_____
4. Attention span or activity level?	☐	☐	_____

If in school, has the patient had…			
1. Tutoring outside the classroom?	☐	☐	_____
2. Placement in a special or resource class?	☐	☐	_____
3. To repeat a grade?	☐	☐	_____
4. Educational or psychological testing?	☐	☐	_____
5. Behavioral problems?	☐	☐	_____

MATERNAL & NEWBORN HISTORY

Pregnancy: (check if the mother had any of the following problems)

☐ excessive wt gain ☐ urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ veneral disease ☐ none
☐ other _____

Did mother smoke, use drugs or alcohol during pregnancy? Yes ☐ No ☐

Birth: Birth Wt _____ Length _____ Apgar _____ Was baby born at: ☐ Term ☐ Early ☐ Late
If early, how many weeks gestation? _____ Was labor difficult or prolonged? Yes ☐ No ☐

_____

_____

Newborn: (check if the patient had any of the following problems)

☐ feeding problems ☐ breast _____ ☐ formula_____
☐ slow weight gain ☐ multiple formula changes ☐ colic ☐ jaundice ☐ recurring vomiting ☐ recurring diarrhea
☐ blood in stools ☐ none ☐ other _____

FAMILY HISTORY

If a family member has or has had any of the following problems, check the appropriate box and list the family member: **M – Mother F – Father S – Sibling GM – Grandmother GF – Grandfather A – Aunt U – Uncle**

☐ _____ Allergies (food, outdoor,etc)
☐ _____ Anemia/Blood disorder
☐ _____ Arthritis
☐ _____ Asthma
☐ _____ Birth defects
☐ _____ Bladder/Kidney
☐ _____ Cancer
☐ _____ Deafness
☐ _____ Diabetes before age 50
☐ _____ Drug/Alcohol abuse
☐ _____ Drug Allergies
☐ _____ Ear Infections/tubes
☐ _____ Eczema
☐ _____ Emotional/Behavioral
☐ _____ Epilepsy/convulsions
☐ _____ Eye/Visual problems
☐ _____ Heart attack/stroke before age 50
☐ _____ Heart problems, other
☐ _____ Hereditary Problems
☐ _____ High blood pressure before age 50
☐ _____ High cholestrol
☐ _____ Immunity Problems/HIV
☐ _____ Learning problems/attention span
☐ _____ Liver Disease
☐ _____ Mental Illness
☐ _____ Mental Retardation
☐ _____ Migraine Headaches
☐ _____ Obesity
☐ _____ Respiratory Infections
☐ _____ Stomach/GI issues
☐ _____ Thyroid or endocrine problems
☐ _____ Tuberculosis
☐ _____ Other _____

PROVIDER COMMENTS:

_____

_____

_____