

# **Pediatric Partners of Stafford**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

If the adults in the household work outside of the home, what childcare arrangements are made for this child?  
\_\_\_\_\_

## **Pregnancy and Birth** Please circle yes or no, or leave blank if uncertain

- |   |       |    |
|---|-------|----|
| 1 Did the mother have any illness during pregnancy?                                   | Yes   | No |
| 2 Were any other medications other than vitamins and iron taken during the pregnancy? | Yes   | No |
| 3 Was the baby born on the calculated due date?                                       | Yes   | No |
| 4 What was the birth weight?  | _____ |    |
| 5 Did the baby have any trouble starting to breathe?                                  | Yes   | No |
| 6 Did the baby have any trouble while in the hospital? (jaundice, infection, other?)  | Yes   | No |

## **Past Medical History** Please circle yes or no, or leave blank if uncertain

- |   |       |
|---|-------|
| 1 Where has your child gone for check-ups until now?  | _____ |
| 2 Date of child's last check-up?  | _____ |
| 3 Date of last dental check-up?   | _____ |
| 4 Has your child had any allergic reactions to any medications, food, insect bites, or immunizations? | _____ |
| 5 If there were any hospitalizations other than birth, please list:                                   | _____ |
| 6 If the child has had any serious injuries, please list:   | _____ |
| 7 If there are any medications taken regularly, please list:  | _____ |

## **Family History** Please circle yes or no, or leave blank if uncertain

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

## **Feeding and Nutrition** Please circle yes or no, or leave blank if uncertain

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

**Review of Systems**

Please circle yes or no, or leave blank if uncertain

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

**Development and Behavior**

Please circle yes or no, or leave blank if uncertain

- |  |       |    |
|--|-------|----|
| 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 they were 18 months?  | Yes   | No |
| 4 Does he/ she have any trouble sleeping?  | Yes   | No |
| 5 What grade is he/ she in?  | _____ |    |
| 6 Has he/ she had any trouble in school?   | Yes   | No |
| 7 Does he/ she get along well with other children?   | Yes   | No |
| 8 Please circle if your child has had any of the following problems with: toilet training, bad temper, hyperactivity, nightmares, speech, or discipline. |       |    |

**Safety and Environment**

Please circle yes or no, or leave blank if uncertain

- |  |     |    |
|--|-----|----|
| 1 Is your water heater set at 120 degrees Fahrenheit?                  | Yes | No |
| 2 Is there a working smoke alarm on each floor of your house?          | Yes | No |
| 3 Does your child always use a car seat or seat belt in the car?       | Yes | No |
| 4 Are there any smokers in your home?                                  | Yes | No |
| 5 Are there any guns in your home?                                     | Yes | No |
| 6 Does your child always wear a bike helmet when riding his/ her bike? | Yes | No |