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, in herited 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 sever 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